

*Health co-ops
around the world*

CANADA



Coordination of the global project

Jean-Pierre Girard, associated researcher, Institut de recherche et d'éducation pour les coopératives et les mutuelles de l'Université de Sherbrooke (IRECUS), Sherbrooke, Canada, and member of the board – Commissioner for North America Region – International Health Cooperative Organisation (IHCO)

Research, translation and writing

Geneviève Bussière, research professional, IRECUS

With the collaboration of

Catherine Larouche, research professional, IRECUS

Editing

Carole Hébert, IRECUS

Direct correspondence to the coordinator

Jean-Pierre.Girard@USherbrooke.ca
<http://www.usherbrooke.ca/irecus/>

Original version

English

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Nova Scotia Co-operative Council
MAKING A DIFFERENCE IN NOVA SCOTIA COMMUNITIES

The views expressed in this report are not those of IHCO

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Introduction

Health co-ops around the world are a series of publications showing the contribution of health co-ops in the health system from a national perspective. The project has been conducted under a mandate of the International Health Co-operative Organisation (<http://www.ica.coop/ihco/>).

Each case includes a snapshot of the national health system, information on the presence of health co-operatives and practical references. It is based on a survey conducted in 2007 with the kind collaboration of many people involved in health co-ops and other relevant organisations located in targeted countries. The series includes the following national cases:

- ✓ Canada
- ✓ United States of America
- ✓ Benin
- ✓ Uganda
- ✓ Mali

The relation between this research project and the very important study conducted in 1995 and 1996 by the United Nations (published in 1997 under the name *Cooperative Enterprise in the Health and Social Care Sector A Global Survey*), as well as the methodological framework are presented in the document:

- ✓ Global background and trends from a health and social care perspective.

Country Statistics¹

Total population: 32,268,000

Gross national income per capita (PPP international \$): 32,220

Life expectancy at birth m/f (years): 78/83

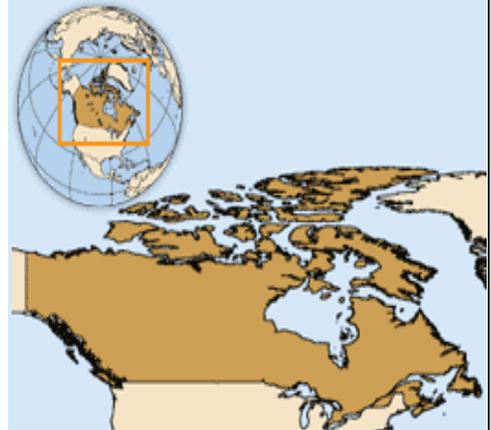
Healthy life expectancy at birth m/f (years, 2002): 70/74

Probability of dying under five (per 1 000 live births): 6

Probability of dying between 15 and 60 years m/f (per 1 000 pop.): 90/56

Total expenditure on health per capita (Intl \$, 2004): 3,173

Total expenditure on health as % of GDP (2004): 9.8



Figures are for 2005 unless indicated. Source: [World Health Statistics 2007](http://www.who.int/countries/can/en/)

¹ Statistics extracted from: World Health Organization (WHO) – Canada: <http://www.who.int/countries/can/en/>, viewed 02/2007.

Snapshot of Canada's Health System²

Organizational Structure of the Health System

Canada has a predominantly publicly financed health system with services provided through private (for-profit and not-for-profit) and public (arm's-length or state-run) bodies. There are 13 single-payers, universal systems for “medically necessary” or “medically required” services – largely hospital and physician services defined as “insured services” under the federal Canada Health Act. The 13 provinces and territories vary considerably in terms of the financing, administration, delivery modes and range of public health care services.

The federal government is responsible for collecting and providing health data, research and regulatory infrastructure, in addition to directly financing and administering a number of health services for selected population groups.

There are three main levels to the organizational structure of the health system: the federal government, the provinces and territories, and the intergovernmental level.

Health Care Financing and Expenditure

The main source of health care financing in Canada is taxation by the provincial, territorial and federal governments (70% of total health expenditure), the bulk of which comes from individual income taxes, consumption taxes and corporate taxes. In addition, some provinces raise supplementary health revenues through earmarked taxes known as premiums. Private financing is split between out-of-pocket payments and private health insurance. The remaining expenditure comes from social insurance funds, mainly for health benefits through workers' compensation, and charitable donations targeted to research, health facility construction and hospital equipment purchases.

In Canada, the total health care expenditure represented approximately 9.8% of the GDP in 2004. Government expenditure represented 69.8% and private expenditure 30.2% of the total expenditure on health.

Health Care Provision

Public health services are categorized by six discrete functions: population health assessment; health promotion; disease and injury control and prevention; health protection; surveillance; and emergency preparedness and response. The federal, provincial and territorial governments, as well as regional

² Information extracted directly from the Canada HIT Summary – European Health Systems Observatory. The statistics in the boxes are from WHO - core health indicators.

Sources:

- European Health Systems Observatory, HIT at a glance summary, <http://www.euro.who.int/Document/E87954sum.pdf>, 2005
- WHO statistics – Core health indicators (2007), http://www.who.int/whosis/database/core/core_select.cfm, viewed 07/2007.

health authorities, perform some or all of these functions, and all governments appoint a chief public/medical health officer to lead their public health efforts. In addition, the Canadian Public Health Association is a voluntary organization dedicated to improving the state of public health in Canada.

Under the Canada Health Act, all residents of a province or territory are eligible to receive “insured services” free at the point of delivery. This includes landed immigrants after an initial residency period (but not foreign visitors), as well as serving members of the Canadian military or the Royal Canadian Mounted Police and inmates of federal penitentiaries.

General practitioners, or family physicians, serve as the patient’s first point of contact; they are gatekeepers to higher levels of the health system. Physicians typically work independently on a fee-for-service basis. Patients have freedom of choice in selecting a family physician, although most choose to have long-standing relationships with their family physicians.

Virtually all secondary, tertiary and emergency care, as well as the majority of specialized ambulatory care and elective surgery, is performed within hospitals. The prevailing trend for decades has been towards the separatist model of hospital, in which the hospital specializes in acute and emergency care, while primary care is left to family physicians or community-based facilities, and long-term care to nursing homes and similar institutions.

In 2000, the physician density per 1000 population in Canada was of 2.14 and the nurse density, 9.95. Hospital beds per 10 000 population totaled 36 in 2003.

Developments and Issues

While the health care system has been successful in maintaining a high level of population health and has undergone a series of reforms, many challenges are emerging. These include the ageing population, increasing health care expenditure, particularly for pharmaceuticals, lengthy waiting times, and shortages of health human resources.

The provincial and territorial Medicare systems continue to uphold the fundamental objective as outlined in the Canada Health Act (1984) to deliver “medically necessary” or “medically required” services on a universal basis without financial obstacles. Although financial barriers to physician and hospital services have been removed, there are some nonfinancial barriers, including timely access to certain types of health care, namely diagnostic test and surgical procedures, specialist physicians and even family physicians in some parts of the country.

In July 2005, in the case of *Chaoulli v. Quebec*, the Supreme Court of Canada decided that the Government of Quebec’s prohibition on private health insurance was contrary to that province’s, Charter of Human Rights and Freedoms in a situation when an individual’s lengthy wait for Medicare services might seriously compromise the health of that individual. This decision calls into question the Canadian model of single-tier Medicare that prohibits or discourages a parallel tier of private insurance for services covered under Medicare.

Health Co-operatives in Canada

Due to the universal health system in place in Canada, health co-operatives can be somewhat limited in their actions. For example, user-owned health co-operative clinics in Canada cannot restrict access to their services only to their members; they must make them available to the population at large. It can therefore be challenging to retain members and attract new members once the coop is up and running since it is not necessary to be a member in order to benefit from the services. Canadian health co-operatives need to be creative in the way they organise and operate and in developing cooperative advantages for their user members.

Even so, the universal system has not hindered the recent development of health cooperatives in the country. With a strong debate currently brewing around the reform of the health system to find a remedy for exploding costs and lengthy waiting time for services, various options are being brought to the table; to privatise or not to privatise, to encourage public-private partnerships or not, etc. The cooperative option is increasingly making headlines as a viable alternative to private-for-profit intervention in the health care system of the country and as a way of increasing citizen participation in matters relating to their health. A book published in 2006 by Jean-Pierre Girard, “*Notre système de santé, autrement – l’engagement citoyen par les coopératives* (Our health system in another way – citizen engagement through cooperatives)”, brings forth the potential of health cooperatives in the health care sector of Canada by highlighting successful experiences in the country and elsewhere. In a recent provincial election campaign in the Canadian province of Québec, the cooperative option in health care was even part of the political discourse of some parties – evidence that it is gaining ground or at least that it is starting to be seen as a serious alternative.

Result of the Study³

In Canada a total of approximately 117 co-operatives offering health services were identified through this study ranging from co-operative health clinics (traditional and alternative medicine), to paramedics’ cooperatives, to homecare co-operatives. An important regional distinction is the fact that 77 (66%) of these are concentrated in the province of Québec. The remainder 34% is spread out in different provinces throughout the rest of the country. There is no national apex organization that unites health cooperatives however, some federations exist at the provincial level such as the *Fédération des coopératives de services à domicile du Québec* (FCSDQ), the *Fédération des coopératives des paramédics du Québec* (FCPQ) and the Saskatchewan Community Health Co-operative Federation.

Given the important regional concentration of health co-operatives in Québec, the results will be presented separately for this province to the rest of the country.

Cooperative Health Care in Canada (except Québec)

For all Canadian provinces excluding Quebec, a list of health cooperatives was provided by the Co-operatives Secretariat, Government of Canada. Forty cooperatives received questionnaires of which 13

³ All information provided on health cooperatives in Canada was collected through a survey carried out between July 2007 and April 2008.

were completed and returned. The co-operatives that chose to participate in the study were 3 user-owned, 7 multi-stakeholder and 2 provider-owned co-operatives.

Altogether, these 13 organizations deliver services to more than 28,000 users and have a total of more than 11,200 members of which 10,610 are users- members. In addition, they employ around 278 people and generate near 11.5 million dollars annual revenue. Approximately 34 physicians and 32 nurses work or collaborate with these coops out of a total of more than 130 health professionals involved.

There are diverse examples of health cooperatives throughout the country. However, most of them are smaller organizations operating at the municipal or regional level. They are involved in a variety of activities such as managing one or several health clinics, dispensing home care services, operating a long term care facility and specializing in the care of mental illness or disabilities.

Let's get to know some Canadian health co-operatives!

Multicultural Health Brokers Cooperative

The *Multicultural Health Brokers Cooperative*, a provider-owned organization of around 26 members in the city of Edmonton, Alberta, came into being in 1998. Its founders were motivated by the will to combat social and economic inequity in the community and to see what happens when front line insight drives an organization. They came together for self-employment but also because they had experienced economic and social exclusion and did not want others to experience the same. The cooperative's main purpose is to enhance the health of the immigrant and refugee population through health education. Over time however, the practice has evolved to touch different levels of intervention. The coop's Co-Executive Director, Yvone Chiu, states that when working with a population that is marginalised, the practice becomes holistic. Since most families who access this coop have limited English, they provide holistic support helping them link with other services they would need such as mental health, housing, etc and they also have contracts with local health authorities in the area of maternal child health. In addition, they have many mutual support groups for families to come together to learn and support each other. Finally, they also work as brokers in the sphere of community development and mobilisation creating strategic networks and alliances with the health sector and others thus showing the power of collaborative care.

The cooperative now caters to the health needs of approximately 1,500 users annually. They directly provide health promotion and preventive health services. As for curative, rehabilitative and palliative care, they are involved indirectly by acting as a bridge between those services and their users. The services are delivered at their center and also throughout the community in the form of navigational support throughout all the health services.

Another interesting aspect of this coop is the members. Many of them were trained health professionals in their countries who have been unable to practice here (3 doctors, 2 nurses, 2 social workers, 2 teachers and 3 community development workers). Their knowledge helps them be able to effectively orient their users.

In the last two years, they have worked hard to partner with local authorities to open a health clinic for refugees. While this partnership is not a cooperative, it will be focused on public participation. They want to keep looking into community determination for addressing issues of refugee health. In order to

do so, they face the extra burden of dealing with public misunderstanding of their services. Since many people don't understand the reality of immigrants and refugees, it has been difficult to get the government to recognize that they are an extension of services and to create formal alliances with them.

Nor'West Co-op Community Health Centre Inc

Another example is that of the Nor'West Co-op Community Health Centre which works in collaboration with individuals, families and communities, to promote health and enhance the safety and well-being of identified populations in the community of Inkster (Winnipeg, Manitoba). They consider themselves leaders in innovative, collaborative, client-focused health services of the highest quality. This multi-stakeholder cooperative was founded in 1972 motivated by a desire to provide the best possible health care to the community at the most realistic cost. The founders set out with the idea that:

At the Nor'West centre preventive care will be a fact, not a concept; the physician will become a member of a health care team, not the leader; the patient will become an individual, not an illness; and health care will involve the dentist, the nurse, the nutritionist, the social worker, the pharmacist, the community worker and the community working together, not in isolation from each other⁴.

The cooperative currently employs 54 people and has around 741 registered members. However, between 3,500 and 4,000 people directly use their services without counting the 30 000 residents of Inkster who regularly benefit from their Newsletter, Inkster in Action Initiative and Community Development Initiatives.

They are involved in health promotion, prevention and curative activities. Their program employs a broad definition of "health" with promotion and prevention as key elements and featured in each staff members' job description. One such Health promotion program is the Inkster in Action, a 3 year joint health promotion initiative to promote physical activity and nutrition in Inkster community. Another program is the Interdisciplinary Primary Health Care Services, which includes an integrated team of physicians, primary care nurses, social workers, nurse practitioners, health promoter/dietitian, community facilitators, reproductive health educators who offer services by phone and in person such as nursing triage, diagnosis and treatment of minor illnesses and injuries, chronic disease management, prenatal care, reproductive care, teen health clinics, Baby Day, counseling, referral and advocacy.

Nor'West has contracts with the government for the delivery of health services to the population through several Service Purchase Agreements. The health services are delivered in a health centre but Nor'West also does some homecare and some out of establishment promotion and prevention activities. The services are offered at one main site with two satellite sites (Daycare and Immigrant Women's Counseling Services) in addition to 3 resource centers and 4 community Teen Health Clinics (two in schools and two in the resource centers); most of programming takes place in the community and resource centers as well as workplaces in Inkster community.

Community residents choose the lifetime membership and become a member in order to have the right to vote at AGM and become more involved in the programs via becoming a Board Member or Volunteer. Others join to receive information and updates via newsletters. Some also want to make

⁴ The Story of Nor'West Co-op Community Health Centre, information provided in survey for this study.

one-time or ongoing donations. All members have access to the services provided if they meet the eligibility criteria - but one does not have to buy a membership in order to use the services.

Nor'West is the only Health Co-op in the Province of Manitoba and has been trying to promote the centre and its benefits in the province and nationwide. The promotion of the Co-op and a membership drive were identified as priorities at the strategic planning session in May 2007. They are heading into the development of the Inkster Access Centre in partnership with the Winnipeg Regional Health Authority and Family Services and Housing as a 3rd partner and a Co-op.

The coop has been recognized as one of 5 health centers across Canada to practice Interdisciplinary Collaboration in Primary Health Care and was chosen to showcase its practice as part of the Enhancing Interdisciplinary Collaboration in Primary Health Care Initiative 2007. It also received in 2006 a Co-operative Achievement Award by the Manitoba Co-Op Association.

Cooperative Health Care in the Province of Québec

In Québec, 41 individual health cooperatives and 2 federations were approached to participate in the study. Of these, 9 individual cooperatives and the 2 federations returned the completed survey. In Québec, health cooperatives can be divided into 3 categories: health clinics, paramedics and homecare.

Health Cooperative Clinics

According to data from the Quebec Government's Co-op Department (*Direction des coopératives du Québec*), of the 21 health cooperative clinics currently operating in Québec, the oldest, Coopérative de solidarité santé Les Grès was founded in 1995 and the two newest additions (at the time of this study), Coopérative de solidarité en soins de santé du coeur de la Gatineau and Coop santé Eastman - coopérative de solidarité, were founded respectively in January 2007 and April 2007. Health cooperative clinics are somewhat of a novelty and seem to be in full development in the province of Québec. In fact, the majority of existing cooperatives were founded between 2000 and 2007 and, apart from the cooperatives mentioned in this study, there is evidence of several health cooperative projects currently developing and fuelling a lot of innovation. This represents close to 10 new projects including the first case in the world of a health co-op located in a University: coop de santé de l'Université de Sherbrooke and also, Coopérative de santé Robert Cliche, the first health co-op offering services at a region scale.

At the present, except for the latest case, these cooperative clinics tend to operate mostly at the municipal level, drawing their membership from and offering their services to the population of one city or town and immediate area.

Information provided by the Direction des Coopératives indicates that the dominant model for health cooperative clinics in Québec is the multistakeholder or "*solidarité*" model as it is called. In fact, around 81% of the health cooperative clinics have adopted this model. Only 3 cooperative clinics are user-owned and 1 is provider-owned.

The 9 cooperative clinics that answered the survey included 7 multistakeholder cooperatives, 1 user-owned cooperative and 1 provider-owned cooperative. Altogether, these clinics employ a total of 38 administrative workers or health professionals. Approximately 50 000 people are using their services, 28 000 of which are registered as members. A total of 49 physicians are working in partnership with these clinics. Based on realistic projections, Aylmer Health Co-op should reach 10 000 user members by 2008.

The motivation behind the creation of health cooperative clinics, according to the surveys, seems to be linked to the need for people to either maintain health services in their communities (when clinics or doctors threaten to close down) and or attract medical personnel. This last point refers to the effect of the current medical personnel (doctors and nurses) shortage in the province. It seems to be the philosophy – “if you build it, they will come!” Citizens form a cooperative to provide the necessary infrastructure to attract doctors and other medical personnel. The cooperative takes care of all the administrative aspects of the clinic thus taking the financial and time burden away from the doctors.

Let’s look at a few examples of health co-operatives operating in the province of Quebec!

Coop de Solidarité Santé de Pointe-du-Lac

One example is the Coop de Solidarité Santé de Pointe-du-Lac of Trois-Rivières. It came into being in 2006 with the short term objective of insuring the survival of the medical clinic of Pointe-du-Lac which had been operating for 20 years. The cooperative wished to retain the services of the doctors in the clinic and to recruit new doctors as well as other medical personnel such as a nurse in order to offer a wider range of services. They also wished to take over the financial management of the medical clinic in order to free doctors of administrative tasks and financial burdens. The idea was to eventually offer the members a pro-active cooperative that offers several healths related services all located under one roof.

The cooperative now caters to the health needs of 4332 users. It is involved in various health promotion activities such as informing people through their website, handing out flyers, giving conferences on nutrition, etc. It also works at the prevention level by encouraging annual check-ups and diagnosis testing. Curative care is provided by its doctors and nurses through treatments, prescribed medication and references to specialists such as physiotherapy, occupational therapy, etc. Finally, it is also involved in palliative care. Its services are delivered in different types of establishment. Apart from the health clinic, the cooperative provides health services in the home, it collaborates with a palliative care residence (*Maison Albatros*) and it also does out of establishment promotion and prevention activities.

Paramedics’ Cooperatives in the Province of Québec

The Fédération des coopératives des paramédics du Québec (FCPQ) founded in 2006, reports a total of 8 provider-owned paramedics’ cooperatives currently operating in the province of Québec. The oldest of these was founded in 1988 and the most recent in 2007. Together, they have a total of 1070 member paramedics (emergency medical personnel) and approximately 145 000 people use their services per year. The paramedics work in a pre-hospital setting providing mobile emergency services. The FCPQ - whose mission is to represent its cooperative members, offer those services and support the emergence

and realization of projects related to the health sector - reports that its members are involved in health promotion services and curative health services. They have contracts with the government for the provision of emergency health services to the population.

The FCPQ indicates that paramedics become members of the cooperatives because it allows them to participate in the orientation of the company, which they collectively own and they benefit from the advantages related to the cooperative model. Advantages for the paramedic members includes better retirement conditions, fiscal advantages and also participation in the collective decision making process of the cooperative. According to the FCPQ, paramedics' coops face the major challenges of countering the exodus and improving the retention of paramedic personnel as well as improving visibility and knowledge of the paramedic profession by the general public and partners of the health sector.

Homecare Cooperatives in the Province of Québec

Homecare cooperatives, as they operate in the province of Québec, register somewhere on the line between health and social care cooperatives due to the type of services they offer. In fact, the services offered by these homecare cooperatives are mostly domestic help services with personal care services presently occupying a smaller proportion of their workload. The *Fédération des coopératives de services à domicile du Québec* (FCSDQ) founded in 1996, groups together 21 (out of a total of 48 homecare cooperatives in the province) including 6 user-owned and 15 multistakeholder. The oldest cooperative member was founded in 1989 and the most recent in 2007. Together, they have a total of 1088 members including users, providers and support members⁵. Approximately 14 188 people use their services per year, the majority of them being elderly persons above 65 years of age.

The services are provided in the user's home. The FCSDQ - whose mission is to ensure the coordination and development of a network and offer services to cater to the needs expressed by its members in order to support them in the realization of their mission with efficiency and autonomy – states that all 21 of its member cooperatives are involved in preventive health activities through their domestic aid services and 14 of them are also involved in curative health services through the personal aid services they provide. The homecare cooperatives have contracts with the government for the provision of services to the population. Through the PEFSAD – a program from the Department of Health and Social Services that grants financial exemption for the users of domestic aid services - the cooperatives receive funds to finance the management of their case loads and the growing number of users.

The FCSDQ indicates that users become members of the cooperatives to access domestic aid services and benefit from the PEFSAD, to discourage illegal domestic aid practices and to reap the benefits of the cooperative and community spirit. Advantages for the user members and provider members include participating in defining the services offered by the cooperative and in helping manage the organization.

According to the FCSDQ, during the next decade, the growing number of elderly members in the cooperatives will surely require that they re-examine their portfolio of services in favor of a greater diversification. The most required services will be personal care, monitoring and companionship to allow caregivers, such as friends and family, time off.

⁵ (data for worker members was not available)

Contacts for Health Cooperatives in Canada

- Alberni Valley Housing and Health Care Co-operative
Barbara Stevenson
4200 10th Avenue, Port Alberni, British Columbia, V9Y 4X3
250-724-6541, ext. 232
bstevenson@acccs.ca
- Care Connection Health Services Co-operative
Laura Raph, Operational Coordinator, founding member
2251 Buffalo Dr., Mission, British Columbia, V2V 4P5
www.careconnectionco-op.ca
1-877-826-2667, 604-826-6112
laura@careconnectionco-op.ca
- Chignecto Manor Co-operative Ltd.
Sherly Morris, Administrator
24 Bayview Manor Road, Advocate Harbour, Nova Scotia, B0M 1A0
902-392-2028
chignectomanor@ns.aliantzinc.ca
- Co-operative Heath Centre Prince Albert Community Clinic
Joanne Thiessen, Executive Director,
110 8th Street East, Prince Albert, Saskatchewan, S6V 0V7
pachcqlx.sasktelwebhosting.com/
306-953-6213
cdochylo@paphr.sk.ca
- Multicultural Health Brokers Co-operative
Yvonne Chiu, Coordinator
10867 - 97 Street, Edmonton, Alberta, T5H 2M6
yvonnechiu@shaw.ca
- Nor'West Co-op Community Health Centre Inc
Nancy Heinrichs, Executive Director
103 – 61 Tyndall Avenue, Winnipeg, Manitoba, R2X 2T4
www.norwesthealth.ca
204-940-3248
nheinrichs@wrha.mb.ca
- Pacific Rim Health Cooperative
Barbara Stevenson, Executive Director
250-724-6541, exec. 4
Bstevenson@acccs.ca

Contacts for Health Cooperatives in Canada (suite)

- Tignish Health Co-op Ltd.
Wendy Arsenault, Manager
P.o Box 118, Tignish, Prince Edward Island, C0B 2B0
902-882-2260
- Beiseke Medical Coop LTD
Fred Lyczewsky, Secretary Treasurer
Box 93, Beiseker, Alberta, T0M 0G0
403-947-2145
- Crocus Co-operative
Patricia Hanbidge, Executive Director
106 Ave B South, Saskatoon, Saskatchewan, S7M 1M1
www.crocuscooperative.org
306-655-4970
patricia.crocus@hotmail.com
- Regina Community Clinic
Mary Flynn, Executive Director
1106 Winnipeg Street
Regina, Saskatchewan, S4R 1J6
www.reginacomunityclinic.ca
306-543-7880
mflynn@reginacommunityclinic.ca
- Samtak Coop Inc.
Iris Jonsson, Board Member
204-734-2807
fperrin@mts.net
- Weldon Co-operative Home Care Ltd.
Roxanne Peterson, Administrator
Box 220, Weldon, Saskatchewan, S0J 3A0
306-887-2888

Health Coops in the province of Québec

- Fédération des coopératives des paramédics du Québec (FCPQ)
Jean-François Grenier – Executive Officer
4135, rue Lesage, Sherbrooke, Québec, J1L 5Z9
819-569-5559
jfgrenier@fcpq.org
- Fédération des coopératives de services à domicile du Québec (FCSDQ)
Eric Martel – Project Officer, Research and Development
5955, rue Saint-Laurent, bureau 203, Lévis, Québec, G6V 3P5
www.fcsdq.coop
418-837-8882
eric.martel@fcsdq.coop
- Coop de services de santé Robert Verrier
Claude Verrier, Président
4075 Martel, Saint-Cyrille-de-Wendover, Québec, J1Z 1B6
http://www.stcyrille.qc.ca/francais/serv_commu3.asp
819-397-4112
claud.verrier@clauver.com
- Coop de Solidarité Santé de Pointe-du-Lac
Andrée Côté, Coordonnatrice
C.P. 4084, Succ. A, Trois-Rivières, Québec, G9B 7Y6
www.coopsantepdl.ca
819-377-7997
coopsantepdl@cgocable.ca
- Coopérative de Solidarité Santé de Sainte-Thècle
Marthe St-Arnaud, Présidente
115 rue Lacordaire, Sainte-Thècle, Québec, G0X 3G0
<http://www.coopsanteste-thecle.qc.ca/>
418-289-2888 ou 418-289-2902
- Coopérative Solidarité Santé de Shawinigan
Gilles Marchand, Président
4233 34e Avenue Shawinigan, Québec, G9N 7K9
819-539-2838
legrandgilles@hotmail.com
- Coopérative de solidarité santé globale Saint-Adolphe-d'Howard
Richard Daoust, Président du Conseil
1937 Chemin du Village, suite 102, Saint-Adolphe d'Howard, Québec
819-327-3534
daoustrichard@hotmail.com

Health Coops in the province of Québec (suite)

- Centre de soins de santé intégré coopératif CSSIC
Paul Lépine, Président
622, rue St-Joseph Est, Québec, Québec, G1K 3B9
www.lamaisondelasante.qc.ca
418-650-2666
ms@mediom.com
- Coopérative de Solidarité santé Les Grès
Danielle Carbonneau, Présidente
190 rue St-Honoré, bureau 202, St-Étienne-des-Grès, Québec, G0X 2P0
819-228-9422
danielle.w.carbonneau@desjardins.com
- Coop Santé Aylmer
Bernard Gélinas, Directeur Médical
67 rue du Couvent, Gatineau, Québec, J9H 6A2
www.coopsa.org
819-684-1234
coopsa@videotron.ca
- Coopérative de Solidarité-Santé de Contrecoeur
Sylvie Mireault, Présidente
4915 Marie-Victorin, Contrecoeur, Québec, J0L 1C0
www.coopcontrecoeur.com
450-587-2667
info@coopcontrecoeur.com