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Just Health: Case Studies of Worker Cooperatives in Health and Care Sectors

Introduction

Adrienne Eaton, PhD and Adria Scharf, PhD

RUTGERS
School of Management
and Labor Relations

**Institute for the Study of
Employee Ownership and Profit Sharing**

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Introduction

As a society, we underpay and under-support—under-care-for—the very workers we rely on to provide health and care services to others. The COVID-19 pandemic briefly spotlighted this fact as health workers braved risks to care for the vulnerable. The worst of that crisis has passed—but the extractive business models that structure health and care work under American capitalism endure.

The way we structure work, and ownership, in health, matters. Healthcare is the largest employer in the country by many estimates.[1] Healthcare workers account for 12% of total employment—not including the self-employed or the millions of workers who perform health-related care work, such as home care, but are omitted from many statistics describing the formal health sector.[2]

This volume documents—for the first time—healthcare enterprises that take the form of worker cooperatives. As worker-owned and governed businesses, these cooperatives are breaking with prevalent ownership and organizational models to forge a fundamentally different, more worker-centered approach.

Healthcare Provision

The country's massive healthcare system is, on the one hand, so complex and sprawling as to defy characterization. On the other hand, it is so distinct that we can make several broad observations. Relative to many other industrial countries, healthcare in the United States is comparatively:

- Highly privatized and commercialized; the U.S. relies on private enterprise to a greater extent than other countries to meet its population's health and care needs.[3]
- Marked by occupational stratification and extreme disparity.
- Staffed by large numbers of low-paid workers who are disproportionately BIPOC (Black Indigenous and People of Color) and immigrant women.

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[1] Earlene K.P. Dowell, "Health Care Still Largest U.S. Employer." October 14, 2020, https://census.gov/library/stories/2020/10/health-care-still-largest-united-states-employer.html.
[2] "Total Health Care Employment," Kaiser Family Foundation, May 1, 2021, https://www.kff.org/other/state-indicator/total-health-care-employment; "Health Care Employment as a Percent of Total Employment," Kaiser Family Foundation, May 1, 2021, https://www.kff.org/other/state-indicator/health-care-employment-as-total. Health Care Employment includes these subsectors in the U.S. Bureau of Labor Statistics National Industry-Specific Occupational Employment and Wage Estimates: Ambulatory Health Care Services, Hospitals, and Nursing and Residential Care Facilities. The term "medical industry" encompasses healthcare providers and services, as well as the manufacture of equipment and supplies, healthcare technology, research and development, and pharmaceuticals.
[3] Willem Adema and Maxime Ladaique, "How Expensive is the Welfare State?: Gross and Net Indicators in the OECD Social Expenditure Database (SOCX)," *OECD Social, Employment and Migration Working Papers*, November 13, 2009, https://www.oecd-ilibrary.org/social-issues-migration-health/how-expensive-is-the-welfare-state_220615515052.

In addition, many health-providing organizations are managed hierarchically in ways that do not allow meaningful worker control or voice. This is true across for-profit, nonprofit, and public settings (with many exceptions, including in unionized settings). While this is a fact of life across much of the economy, it can have devastating consequences in healthcare if frontline providers, who may have the most knowledge about the patient or client, are not heard.

Ownership

In the United States, healthcare is privately delivered and funded to a degree rarely seen in other countries. According to the American Hospital Association, of the 6,093 hospitals in the country, roughly one-third operate as for-profit investor-owned businesses and about half are private nonprofits; different levels of government run the rest.[4] Outside of hospitals, too, much healthcare is delivered by private for-profit and nonprofit entities. For example, one-third of the 233,350 physical therapists registered in the United States work in private outpatient offices. In addition, nearly 45% of psychologists work in private practice, according to a 2015 survey by the American Psychological Association, with 23.6% working in hospitals or organized social service settings.[5]

Evidence is mixed on the impact of for-profit versus nonprofit status in hospitals. However, multiple studies have found significantly poorer care and more deficiencies in for-profit nursing homes.[6]

For-profit health businesses largely have ownership models that extract and concentrate wealth and profits into the hands of owners, shareholders, and investors.[7] Three major trends are restructuring ownership patterns within large swaths of for-profit private enterprise healthcare:

- First, hospitals and hospital systems are consolidating and merging, expanding into ambulatory, clinical and community-based care and buying up independent practices.[8]

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[4] "Fast Facts on U.S. Hospitals, 2022," The American Hospital Association, accessed December 1, 2022, https://www.aha.org/statistics/fast-facts-us-hospitals. More than half of community hospitals are now part of a "System."

[5] Auntré Hamp et al., *2015 APA Survey of Psychology Health Service Providers* (Washington, DC: Author, 2016), https://www.apa.org/workforce/publications/15-health-service-providers/report.pdf. About half of respondents reported self employment (48.9%) and 43.6% salaried employment.

[6] "Non-Profit vs. For-Profit Nursing Homes: Is There a Difference in Care?" The Center for Medicare Advocacy, last modified March 15, 2012, https://medicareadvocacy.org/non-profit-vs-for-profit-nursing-homes-is-there-a-difference-in-care/; Haider J. Warraich, "For-Profit Nursing Homes and Hospices are a Bad Deal for Older Americans," *STAT*, April 19, 2021, https://www.statnews.com/2021/04/19/for-profit-nursing-homes-hospices-bad-deal-older-americans/. Critics argue that for-profit ownership models may undermine care while proponents claim that for-profit models increase efficiency.

[7] These may be large investors, public shareholders, entrepreneurs, or for example with independent private practices and PLLCs, they may themselves be licensed care professionals.

[8] Shubham Singhal and Neha Patel, "The Future of U.S. Healthcare: What's Next for the Industry Post-COVID-19," *McKinsey & Company*, July 19, 2022, https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/the-future-of-us-healthcare-whats-next-for-the-industry-post-covid-19. "Hospital systems have been expanding across the care continuum, accumulating assets in ambulatory

- Second, private equity firms, which pool money from groups of investors, are buying more health companies to restructure and sell the companies at a profit; private equity investments in health more than doubled in 2021 from $66 billion to $151 billion.
- Third, franchise models of ownership (in which an individual or entity provides health services under the brand of an established company) are expanding in certain pockets of the sector, among, for example, home care, physical therapy businesses, primary care, and urgent care clinics.[9]

All three trends raise questions about how profit-imperatives might impact workers and the quality of care. By contrast, while they are also private enterprises, worker cooperatives are designed in ways that balance profit-making with worker needs and other values. By design, they give worker owners mechanisms for genuine voice and a share of profits. Their unique organizational structure may have implications not only for workers but for patients as well.

Disparities

Rigid hierarchies and substantial inequalities among occupational groups characterize this sector.[10] Occupations range from the highly educated and typically highly compensated (such as physicians) to less skilled, or skilled but devalued, jobs like certified nursing assistants and home health aides, receptionists, cleaners, and other administrative roles in health settings.[11]

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sites, virtual and digital health, primary care, and post-acute care. A majority of the net patient service revenues of the largest 50 hospital systems are now outside inpatient care."

[9] The COVID pandemic was particularly revealing of the problems facing health care workers including lack of personal protective equipment; by one report, 3,600 U.S. healthcare workers died in the first year of the pandemic. Two-thirds of those who died were people of color. Other healthcare workers experienced moral injury helplessly watching people die. All of this is no doubt a factor in the severe shortages seen in many parts of the sector today. While the pandemic has filled hospitals to bursting points on and off since early 2020, it also, perversely shut down many offices providing more elective or peripheral care in the early months and maintained lower levels of patient volume for additional months.

[10] Ariel C. Avgar et al., "Paying the Price for a Broken Healthcare System: Rethinking Employment, Labor, and Work in a Post-Pandemic World," *Work and Occupations* 47, no.3 (August 2020): 267-436. https://doi.org/10.1177/0730888420923126.

[11] Alethia Jones, "Agents of Change: How Allied Healthcare Workers Transform Inequalities in the Healthcare Industry," in *Structural Competency in Mental Health and Medicine: A Case-Based Approach to Treating the Social Determinants of Health*, ed. Helena Hansen and Jonathan M. Metzl (Springer, Cham, 2019), 191-209. https://doi.org/10.1007/978-3-030-10525-9_16. Boundaries throughout the healthcare professions are maintained by law and regulation and can be contentious battlegrounds for scope of practice policies, conflicts in which professional associations often play a major role. For a discussion of these hierarchies and how they intersect with race, see the link above. A larger circle of care work, which some have called the care economy or the social care sector, supports community health but is not reflected in statistics on the formal health sector. Examples of such care work include home care, some doulas, certain mutual aid efforts, health assistance provided within friendship or familial networks, and other health-supporting care work provided outside of formal employment relationships.

While the mean annual wage for "healthcare practitioners and technical occupations" was $91,100 in May 2021, "healthcare support occupations" (such as home health aides, occupational therapy assistants, and medical transcriptionists) earned wages of just $33,330 at the mean.[12] Many healthcare workers and support workers in healthcare settings contend with low wages, unpredictable hours, limited access to benefits, workplace stress and risk, and low job security. Women, Black, Latinx, and immigrant workers disproportionately perform lower-wage jobs with poor job quality.

We know from the existing literature that the terms and conditions of employment for all of these occupations are essential for patient health outcomes. For example, evidence suggests that lower turnover among home-care providers can improve care quality. In addition, it is worth noting that although support workers such as receptionists and cleaners in healthcare organizations do not directly provide healthcare themselves, they nevertheless help to create the environment in which care is provided and do so with substantial potential implications for health outcomes and service quality, an important metric for many healthcare providers.[13]

Home care requires further discussion. The country's 2.6 million home-care workers, who assist older adults and people with disabilities at home, earn a median annual income of $19,100, according to the research group PHI. Eighty-five percent are women. Sixty-three percent are people of color.[14]

Without question, home-care workers provide services that contribute to the health and safety of the client and can provide valuable information to formal healthcare providers and families. We recognize that state laws strictly differentiate "home care" from "home health care": "Home care" agencies provide help with daily living and nonmedical services to people with functional limitations. "Home health" agencies may provide skilled health services such as nursing care which may involve a written order from a physician. Despite the legal distinction, we understand home care to be intertwined with and indeed a necessary component of health provision in our

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[12] "Occupational Employment and Wages, May 2021," Occupational Employment and Wage Statistics, U.S. Bureau of Labor Statistics, accessed November 1, 2022, https://www.bls.gov/oes/current/oes290000.htm; https://www.bls.gov/oes/current/oes310000.htm/.

[13] Adam Seth Litwin, Ariel C. Avgar and Edmund R. Becker, "Superbugs Versus Outsourced Cleaners: Employment Arrangements and the Spread of Health Care-Associated Infections," *ILR Review* 70, no.3 (May 2017): 610-41.

[14] "Direct Care Workers in the United States: Key Facts," *PHI*, September 6, 2022. http://www.phinational.org/resource/direct-care-workers-in-the-united-states-key-facts-3/.
Note that these estimates include personal care aides who assist with nonmedical activities and home health aides who can perform certain clinical tasks under supervision, as well as some direct support professionals. The majority of these jobs are funded through public insurance sources such as Medicaid and Medicare; low Medicaid reimbursement rates are one cause of low wages among these occupations. See the link above.

aging society. Therefore, we have intentionally included home care cooperatives case studies in this volume.[15]

In the United States, health insurance coverage is predominantly employer-based, with 66.5% of the U.S. population covered by employer-provided health insurance, with the rest covered by public schemes.[16] Among other problems, this system, especially before the advent of "Obama-care" left many U.S. residents uninsured, leading to overuse of emergency rooms, institutions burdened by uncompensated care, gross inequalities in access to care, and poor health outcomes. The U.S. remains at the bottom of developed countries in terms of our healthcare outcomes due in part to our patchwork funding system and to the many perverse incentives in the fee-for-service parts of the system, which reward more care but not high-quality or preventive care.

Moreover, employer-provided health is so expensive as to remain out of reach for most very small employers, leaving their workers to stay uncovered or to pursue other options. Insurance companies' rules and requirements, and coverage decisions, impinge on health organizations and their workers, too—including some of the cooperatives documented here. Like other health-service providers and employers, cooperatives have to contend with the complex array of payers and the bureaucratic requirements of those payers in this "system."

What are the solutions to poor working conditions and disparities? Unionization is undoubtedly one. Unionized healthcare workers are, on average, better paid, more likely to be covered by health insurance and pension benefits, and provided some modicum of voice. But as of 2021, only 7.7% of healthcare (and social assistance) employers and 8.3% of healthcare support occupations were unionized. Those averages across the sector hide variation. In 2018, 14.7% of hospitals and 7.1% of home healthcare services but only 4.2% of physician offices and 1.9% of other health practitioners' offices were covered by unions. In those cases where management and unions have chosen to formalize partnerships, organized voice in the form of worker and union participation in managerial decision-making is further strengthened.[17] The best known of these

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[15] Different entities categorize home care in various ways—as social assistance work, social care work, direct care work, domestic work, or health-related work.

[16] Katherine Keisler-Starkey and Lisa N. Bunch, "Health Insurance Coverage in the United States: 2020," *U.S. Census Bureau Current Population Reports*, September 14, 2021, https://www.census.gov/library/publications/2021/demo/p60-274.html. Many employer-based health insurance programs now also require substantial contributions from employees themselves as percentage of the insurance premium, deductibles and/or co-pays. By some measures however, health costs are over two-thirds publicly funded; David U. Himmelstein and Steffie Woolhandler, "The Current and Projected Taxpayer Shares of U.S. Health Costs," *American Journal of Public Health* 106, no.3 (March 2016): 449-52. https://doi.org/10.2105/AJPH.2015.302997. Many employer-based health insurance programs now also require substantial contributions from employees themselves as percentage of the insurance premium, deductibles and/or co-pays. By some measures however, health costs are over two-thirds publicly funded. See the link above.

[17] Adrienne E. Eaton, Rebecca Kolins Givan, and Peter Lazes, "Chapter 6. Labor-Management Partnerships in Health Care: Responding to the Evolving Landscape," in *The Evolving Health Care Landscape: How Employees, Organizations, and Institutions are Adapting and Innovating*, eds. Ariel C. Avgar and Timothy J. Vogus (Labor and Employment Relations Association/Cornell University Press,

partnerships are in hospital systems, including some huge ones and all public or non-profit. Research suggests that unionization and labor-management partnership can be associated with better health outcomes for patients, likely a result of the better conditions of work, reduced turnover, and protections for worker voice in these settings.[18]

Many labor scholars have noted the historically explicitly racist exclusion of home-care workers from the legal protections of unionization rights.[19] Nevertheless, over the last three decades, some of the largest and most innovative union organizing campaigns have taken place among home-care workers who are independent contractors employed by low-income clients but reimbursed by the state.[20] Home-care workers have also won some protections under the Domestic Workers Bill of Rights passed thus far by 10 states.[21]

Given the structural limits of the existing experiments in unionization and partnership, it is worth examining additional forms of workplace organization that may lay pathways for something new.

One model that differs from for-profit business models in health, and which also differs from hierarchical nonprofit and government models of organization, is the worker cooperative. Worker cooperatives in the health and care sectors are few in number. Still, this close

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2016), 143-70; Thomas A. Kochan et al., *Healing Together: The Labor-Management Partnership at Kaiser Permanente* (Cornell University Press, 2009).

[18] Adam Dean, Atheendar Venkataramani, and Simeon Kimmel, "Mortality Rates from COVID-19 are Lower in Unionized Nursing Homes," *Health Affairs* 39, no.11 (November 2020): 1993-2001. https://doi.org/10.1377/hlthaff.2020.01011; Arindrajit Dube, Ethan Kaplan, and Owen Thompson, "Nurse Unions and Patient Outcomes," *ILR Review* 69, no.4 (August 2016): 803-33. https://doi.org/10.1177/0019793916644251; Michael Ash and Jean Ann Seago, "The Effect of Registered Nurses' Unions on Heart-Attack Mortality," *ILR Review* 57, no.3 (April 2004): 422-42. https://doi.org/10.1177/001979390405700306; Kochan et al., *Healing Together*.

[19] Eileen Boris and Jennifer Klein, "Labor on the Home Front: Unionizing Home-Based Care Workers," *New Labor Forum* 17, no.2 (July 2008): 32-41. https://www.jstor.org/stable/40342996.

[20] Patrice M. Mareschal, "How the West was Won: An Inside View of the SEIU's Strategies and Tactics for Organizing Home Care Workers in Oregon," *International Journal of Organization Theory and Behavior* 10, no.3 (Fall 2007): 386-412. https://doi.org/10.1108/IJOTB-10-03-2007-B006; Patrice M. Mareschal, "Innovation and Adaptation: Contrasting Efforts to Organize Home Care Workers in Four States," *Labor Studies Journal* 31, no.1 (Spring 2006): 25-49. https://doi.org/10.1177/0160449X0603100103; Eileen Boris and Jennifer Klein, "Organizing Home Care: Low-Waged Workers in the Welfare State," *Politics & Society* 34, no.1 (March 2006): 81-107. https://doi.org/10.1177/0032329205284757; Eileen Boris and Jennifer Klein, *Caring for America: Home Health Workers in the Shadow of the Welfare State* (Oxford University Press, 2012); This progress is somewhat threatened by the Executive Orders of Republican governors in some states, and also by the Supreme Court's decision in Harris v. Quinn in 2014 which ruled that care workers could not be required to join a union or pay union dues.

[21] "Passed Legislation: States and Cities with a Domestic Workers Bill of Rights," National Domestic Workers Alliance, accessed December 1, 2022, https://www.domesticworkers.org/programs-and-campaigns/developing-policy-solutions/bill-of-rights/passed-legislation/. New York, Illinois, Oregon, California, Nevada, Connecticut, Massachusetts, Hawaii, New Mexico and Virginia. For details, see the link above.

examination of existing worker cooperatives in health begins to shed light on an emergent organizational form that offers a fundamentally different, more equitable, and worker-centered approach to organizing health work and providing patient or client care. It is a unique model that can give workers of all ranks and occupations in the cooperative an ownership stake, a voice in governance, support, and, unusually, a share of the profits.

This Volume

This volume presents new case studies demonstrating that democratic worker cooperatives have already begun to take root as viable organizational forms, albeit in fairly distinct parts of the health sector. Two of the cases presented are of unionized worker cooperatives. For the most part, though, these organizations are located in settings different from those where major union and labor-management partnerships are being tried.

The nine cases detail, for the first time, at a granular level, how U.S. worker cooperatives in health-related fields are organized, how they govern themselves, and how they prioritize worker well-being while delivering needed services to clients and patients.

By their design as worker-owned and governed businesses, worker cooperatives contrast with predominant business models in which ownership and governing authority are reserved for the few. In cooperatives, worker-owners (who may be called cooperative members) share profits and make significant decisions democratically, either directly or through a system of representation.

The democratic enterprises described in these pages vary in size, structure, workforce demographics, and cultures. They also differ in their membership requirements, wage structures, and the rights and pay they accord to administrative support staff and workers who are not yet owners. Some of the case cooperatives have long track records of demonstrated success. Others are fledgling experiments.

Despite their differences, when we look at these case studies as a whole, several patterns emerge:

- Across the cases, we find pay rates generally equivalent to or above market rate, with profits shares for worker-owners, on top of wages, during profitable periods.[22]
- Nonfinancial benefits are often as salient as financial ones. For immigrants, BIPOC (Black, Indigenous, and people of color), and LGBTQ workers who face discrimination and abuse in conventional settings, the cooperative can mean safety, mutual support, and literal economic survival.
- We see preliminary indications that when workers are owners and are themselves embedded in workplace support systems, they are better able to provide quality care.

[22] Provision of health and other benefits in the worker cooperatives, however, appears to vary by organization size.

- Cooperative governance, founded on the principle of "one person, one vote," means an unusual degree of equality of voice among members across roles and titles.
- We observe, too, that the worker cooperative is a flexible form; a cooperative may be legally structured in a variety of ways, and democratic ownership and governance can be successfully paired with a wide variety of different approaches to day-to-day management and coordination.
- Two examples of unionized cooperatives point to synergies that can result from such partnerships.
- Across cases, we see evidence for the crucial role of ecosystems and partnerships in building cooperative resilience.
- We can also see cooperatives attempting to grapple with the hierarchy and status differentials that plague much of the healthcare system and can create barriers to cross-occupational teams providing care. Of particular interest is the inclusion of clerical and non-provider support staff.
- Cooperatives face institutional and competitive pressures; legal barriers that pose obstacles to democratic ownership; well-financed low-road competitors with large marketing budgets, and the mess that is the U.S. "system," if such a word can be used, for how healthcare is funded here.

The case studies contribute to several broader discussions, from "rethinking the corporation"[23] to envisioning real utopias,[24] alternatives to "racialized capitalism"[25] to "cooperative and participatory forms of organization."[26] We expect these case studies to interest workers, business owners, entrepreneurs, practitioners, advocates, and policymakers. These case studies are also useful teaching resources. (See teaching guide on the Curriculum Library for Employee Ownership website, cleo.rutgers.edu.)

Research Approach

The research draws primarily from semi-structured interviews with cooperative members and secondarily from documents and data provided by the cooperatives. In some cases, interviews with individuals in adjacent and technical support organizations were also conducted.

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[23] Renate Meyer, Stephan Leixnering, Jeroen Veldman (editors), *The Corporation: Rethinking the Iconic Form of Business Organization* (Bingley: Emerald Group Publishing, 2022).
[24] Erik Olin Wright, *Envisioning Real Utopias* (London: Verso, 2010).
[25] Sanjay Pinto, "Economic Democracy Against Racial Capitalism: Seeding Freedom" (Forthcoming).
[26] Joyce Rothschild-Whitt, "The Collectivist Organization: An Alternative to Rational-Bureaucratic Models." *American Sociological Review* 44(4):509–27; Katherine K. Chen, *Enabling Creative Chaos: The Organization Behind the Burning Man Event* (Chicago:: University of Chicago Press, 2009).

To select potential organizations, a list of worker cooperatives in health fields was developed in fall of 2021, with guidance from staff members of the U.S. Federation of Worker Cooperatives, the Democracy at Work Institute, other sector experts, and database searches.

Confirmatory background research was then conducted to ensure that listed organizations were truly worker cooperatives in health-related fields.

Organizations from the final list were recruited to participate with a recruitment letter. To qualify to participate, at minimum one, and preferably several, company contacts were required to provide signed consent to participate in semi-structured interviews.

Research interviews were conducted, and supplementary documents and information were collected between December 2021 and June 2022. Most interviews were conducted virtually. Interviews were recorded and transcribed. The primary company contact was also asked to complete a brief optional survey.

Company-level pay and employment data are compared to industry or occupational data when feasible. In addition, upon completion of case study drafts, interviewees were allowed to review their quotes and, in some cases, review the entire draft, to check for accuracy and provide feedback.

Book Content

Three of the nine case studies presented here examine home care cooperatives, the most common type of worker cooperative in health. Cooperative Homecare Associates (CHCA), the largest worker cooperative in the country with over 2,000 workers, is a unionized worker cooperative organized around a job quality philosophy. Golden Steps is a cooperative of immigrant women from Central and South America for whom the worker co-op provides one of the few available vehicles for organizing collectively. The five small, loosely networked home care cooperatives in Washington state represent the densest concentration of home care cooperatives in any state in the country.

The next three cases examine professional health practices that chose to structure themselves as worker cooperatives in order to build organizations that better reflect such values as equality, community, support, or liberation. These include the large successful Vermont physical therapy practice PT360, which remains the only worker-owned physical therapy practice in the country; Five Point Holistic Health acupuncture and psychotherapy center in Chicago was boosted when a local insurance carrier began covering acupuncture treatments; and a nonhierarchical mental health network based in Queens, Alliance Collective, animated by a desire to achieve an organization that is as free as possible from hierarchy and oppression.

The final three case studies describe worker cooperatives positioned strategically in relationship with larger health systems. Allied Up, for example, seeks to provide an alternative to the low-paid contingent worker staffing model as a unionized cooperative staffing organization for allied health professionals. The Evergreen Cooperative Laundry contracts with the Cleveland Clinic to tap into the economic resources of the enormous health system to sustain jobs and benefits for

excluded communities. Obran seeks to demonstrate the viability of a worker-centered version of a multinational corporate conglomerate by growing its portfolio of small businesses within a cooperative umbrella.

Close

How we structure ownership and work in the healthcare sector matters.

As the baby boomer generation ages, the health and related care sectors will continue to swell. According to the U.S. Bureau of Labor Statistics, "[e]mployment in healthcare occupations is projected to grow 16% from 2020 to 2030, much faster than the average for all occupations, adding about 2.6 million new jobs. As a result, healthcare occupations are projected to add more jobs than any of the other occupational groups."

With a highly corporatized health sector marked by extreme job stratification and low wages seeing the rapid encroachment of profit-extracting private equity, exploration of more democratic alternative approaches to organizing work in health is overdue.

Overview Table

Worker Cooperative	Service	Location	Members / Workers	Revenue	Governance	Founded
Alliance Collective	Psychotherapy	Queens and Brooklyn, N.Y.	6 members/ 6 workers	$200k	Direct decision making through consensus	2018
AlliedUP	Healthcare staffing	Ontario, Calif.	40 to 60 members / 1,000 workers placed in jobs	$10m	Worker owners to hold majority of board seats starting Nov. 2023 Labor-Management Committee Collective Bargaining Agreement (SEIU-UHW)	2021
CHCA	Home care	Bronx, N.Y.	800 members / ~1,800 workers	$56.9m	Managerial team has day to day control However members elected reps to board of directors that has hiring and firing power over the CEO. Workers are also union members and have access to union grievance procedures	1985
Golden Steps	Home care	Brooklyn, N.Y.	6 members/ 6 workers	Unreported	Combination of direct and representative - Elected leadership + worker committees	2011
Obran	Home health	Multiple locations	50 workers in "Physicians Choice" home health portfolio compoany	Unreported	Members may run for board of their own workplace and the board of Obran. Members vote in future board elections and certain special member decisions. May participate in Committees that recommend new ideas to the board. Source: Obran website	2018
Evergreen Laundry	Laundry services for Cleveland Clinic	Cleveland, Ohio	~75 members/150 workers	$10.5m expected in 2022	Worker representatives on board of directors. Cooperative meetings for all members.	2009

Five Point Holistic Health	Acupuncture, bodywork and psychotherapy	Chicago, Ill.	3 members / 15 workers	$605k	Weekly “check-in meetings” Longer strategic owners meetings	2014
PT360	Physical Therapy	Four sites in Chittenden County, Vt.	18 members/ 36 workers	Undisclosed	Members elect board of directors annually. Each member has one equal vote. Five members serve on the board as officers. “Owner Meetings” take place every four to six weeks. Any owner-member can add an item to the agenda. Members discuss and then vote on each agenda item. Decisions are made by majority rule.	2010
Five Washington Home Care Cooperatives: Circle of Life Peninsula, Capital, Ridgeline, Heartsong	Home care	Bellingham, Port Townsend, Olympia, Port Angeles, Anacortes in Wash.	74 members/ 96 workers combined across the five cooperatives	$25k -300k	Boards of individual cooperatives elect worker members of that cooperative.	2009, 2016, 2018, 2020, 2021