



Enabling Policy for Health and Social Co-ops in BC

John Restakis and Ondrej Filip

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Part One - Background & The Case for the Co-op Model

Some History, Some Politics, and Some Economics

The changes in public policy that followed government deficits in the 1980s and 1990s radically altered the role of governments at both federal and provincial levels with respect to the funding and delivery of public services. During this period, the adoption of neo-liberal policies that reduced the role of governments in the provision of public goods and services was also accompanied by growing public disaffection with both the quality of public services and what was perceived as a lack of accountability and value for tax dollars spent on these services.

This combination of factors was decisive in the emergence of new approaches that featured the application of private sector management models to public goods and the growing involvement of commercial interests in the public sector.

In British Columbia, the Liberal government adopted an aggressive neo-liberal approach to public policy and proceeded further and faster down this ideological path than any other government in Canada. One outcome was that the province has been cutting expenditures on health and social care since 2002, while simultaneously increasing the use of private companies for the delivery of health and social services in the province.

British Columbia's health system is organized through six regional health authorities that are responsible for the delivery of health services to meet the needs of the population within their region. More than 90 per cent of the Regional Health Sector funding is provided to the six health authorities for the provision of most local health services, including health promotion and protection services, primary care, hospital services, home and community care, mental health and addiction services, and end-of-life care.

According to an analysis conducted by the Caledon Institute of Social Policy, "health authorities are considering public/private partnerships to address the funding shortfall; revenue generating opportunities such as user fees, retail operations and surgeries for non-residents; and increased use of private labs. Income-testing for the non-health care costs of home and community care services is being considered. Changes to legislation and contracts will enable health authorities to close, privatize or contract out services."¹

As part of a cost cutting strategy in BC, the Province's Regional Health Authorities were required to find ways to reduce expenditures by \$550 million over the three-year period commencing in 2002. The resulting cuts meant the loss of acute care beds, the closure of community hospitals and long-term care facilities and the elimination of 6,500 health care worker positions. Other services such as cleaning and laundry services and hospital catering services were also privatized.

These measures may have scaled back health spending, but there are deep implications for those in need of health care services.

First, the higher cost of providing services through commercial, for-profit companies may ultimately translate into higher insurance premiums and increased health care costs for families and individuals.

Second, health services that are not narrowly defined as front line care or cannot be offered on a profit basis are vulnerable to elimination. This includes reduction or elimination of community service and health promotion programs.

¹ Caledon Institute of Social Policy (2002)

Third, the reduction in publicly provided services means reduced access to acute, emergency and long-term care and the termination or reduction of previously funded home care services such as cleaning, cooking, and personal care.

Today, while general dissatisfaction with the lack of access and perceived low quality of public services continues, the question remains: if governments continue the policy of cutting expenditures to health and social care services and the private market produces only services that generate a profit, is there any other way to address the production and delivery of health and social services that can serve the public interest at an affordable cost?

This paper examines the role that co-operatives are playing in the provision of such services in Canada and abroad, and the impact of government policy, legislation, and operating procedure on the ability of co-operative models to provide these services in BC. The paper also examines other factors - both internal and external to co-op organizations, -that affect the capacity of co-ops to play a more meaningful role in the production and delivery of health and social care services in the province.

What seems clear is that there are effective alternatives to the prevailing view that health and social services must be supplied either by government or the private sector, or some blend of the two as exemplified in the classic public/private partnership approach (PPP).

A third alternative, a social economy model based on consumer control and operating at a community level through a variety of community based, non-profit, co-operative, and social enterprises has been breaking new ground and warrants serious attention by policy makers and legislators. It is an approach that calls into question the appropriateness of either the government or the private sector as the best solution to the current needs of consumers. A social economy approach also requires governments to move beyond the strict utilitarian view of public services that has come with the application of private sector management models to the public sector.

The Case for a Co-op Approach to Health and Social Care

It has often been argued that the private sector is more efficient than the state in the delivery of public services, including health care. Government delivery of these services is criticized as inefficient, not cost-effective, and lacking in the ability to respond to the real needs of consumers. Conversely, it is argued that the contracting out of public services to private providers allows governments to cut expenditures while increasing access and choice through the introduction of competition in the production of these services by the private sector.

This argument continues to gain momentum, particularly in the provision of health care, through its promotion by such powerful interests as the Canadian Medical Association (CMA) with its new head arguing forcefully for the increased use of private clinics for the provision of testing, CT scans, and surgical procedures while doctors continue to work in the public system.

At its 2008 AGM, the CMA approved a motion calling on the organization to “develop a blueprint and timeline for transformational change in Canadian health care to bring about patient-focused care by February, 2009”. The rationale for this shift toward more private care is “better access and patient choice”. In a similar vein, outgoing CMA president Brian Day, a strong proponent of privatized health care, says “Competition, consumer choice and market principles barely exists in our health care system...without competition we cannot expect improvement, let alone excellence”.

However, the use of commercial market analogies like competition and consumer choice to bolster the case for private delivery of health care are deeply flawed on both theoretical and empirical grounds. The principles which apply to the production and distribution of goods and services in the public sector are

wholly different than those that drive the private market for the simple reason that public goods are meant to be accessible by everyone - irrespective of the ability to pay.

The application of commercial principles such as the “right to choose” and “competitive excellence” can apply to public services only if those services remain universally accessible. This is the non-exclusionary principle that defines a public good. The moment an individual is excluded from accessing a health service because they cannot afford to pay for it, that service ceases to be a public good. This would be the immediate consequence of user fees for health services that are not available in the publicly funded system.

If, on the other hand, a health service is provided to all regardless of the cost incurred by the requirement for profit, the entire system becomes far more costly and even less sustainable. Additionally, the private production of public services such as health care generates market failures because private markets take no account of the external benefits (positive externalities) of health care to the broader society.

Because a private market mechanism is constrained by the need to generate a profit, private firms will produce significantly smaller quantities of any public good or will not produce the good at all if profits cannot be realized. This is regardless of the need for the good or the benefit that would accrue to the community as a whole. Market failure of public goods is built into the very structure of a private market model.

The production of public goods by the state is also subject to market failures - but for different reasons.

Direct provision of services by government creates inefficiencies that stem from the nature of a bureaucratic system that generates rent-seeking tendencies – the extraction of value without a commensurate contribution to production. These inefficiencies and increased costs also result from government regulatory and operational procedures. And while governments can correct for market failures and help ensure that an optimal quantity of services is produced, this comes at a cost that becomes unsustainable when the growth in service demand is coupled with the inherent costs of bureaucratic systems.

On top of this, state provided services are inherently inflexible and notoriously poor in responding to the actual needs of individuals. When delivered by centralized bureaucracies, universal access to public services also demands that these services be designed in way that can be applied to large classes of users, not individualized cases.

An alternative to private care on the one hand and traditional government delivery on the other is required if the public nature of health and social care is to be protected and made responsive to the actual needs and expectations of citizens.

Co-op models for the production of both health and social services have shown a remarkable capacity to provide new types of care at a cost, and in a manner, that blends the benefits of a public good with the choice and responsiveness normally associated with a private sector service.

The reason for this stems from the structure of co-operatives as user-owned and operated organizations. Like public services, co-operatives have a mutualistic function –to serve the collective needs of member-owners. But the scale of delivery is much smaller, usually community based, and unlike government systems the design and delivery of these services rests in the hands of co-op members. The operation of these control rights by members also provides the option of choice that is characteristic of the private market.

In the case of health services for example, co-operatives have been shown to offer a patient-focused approach to health care that is a direct consequence of user control over the design and delivery of these services. An examination of some of these models will be presented below.

Similarly in the provision of social care, social co-ops and other forms of social enterprise have increased the range of services available to consumers while simultaneously containing the costs for the provision of these services by the state.

In both cases, the co-op model has been most effective when it is developed as a complement to public services. In those jurisdictions where social co-ops are most advanced, their proponents argue strongly for government to continue playing a central role in the funding and regulation of public services. And in both cases, the existence of government programs that subsidize the cost of providing these services is a key element in the success of the co-op model as a support system to public services and an alternative to privatization.

Moreover, as illustrated by the case of social co-ops in Italy, the multi stakeholder structure of social co-ops is a key factor in the role these co-ops play to lower costs, increase service innovation, address market failures, and respond to the changing needs of individual users. The use of social co-ops has also proven effective in the effort to integrate marginalized and vulnerable populations into the labour force.

Comparative Advantages of the Multi Stakeholder Model

In multi stakeholder models, membership is composed of a variety of stakeholders with a shared interest in the service. These include employees, service users, volunteers, funders, and community and public institutions. The involvement of these groups directly in the production and delivery of the service confers advantages that differentiate these co-ops from conventional non-profits, private firms, and government agencies.

Carlo Borzaga from the University of Trento argues that the multi stakeholder form of social co-ops contributes important comparative advantages in the following ways:²

Since social co-ops are controlled by a variety of stakeholders, costs are contained because they are not controlled solely by those who receive monetary benefits from the organization – employees in the case of non-profits, or investors in the case of private firms. The control rights exercised by consumers and volunteers constrain the distribution of profit and the rise of costs. For this reason, social co-ops can provide services more efficiently.

Costs are further contained by the involvement of consumers and volunteers in the delivery of services. This lowers the cost of production. Consumer and volunteer contributions also lessen the incentive to adopt opportunistic behaviour.

The involvement of multiple stakeholders reduces the traditional asymmetries of information that compromise the efficient delivery of services in non-profits, welfare service models, and private firms. Consumer involvement in particular, increases access to information and raises the levels of transparency and accountability in the organization.

Social co-ops are better able to cope with rationing (of capital) which is a key market failure of government services. The combination of public and private funds that are used to capitalize services is a key strategy for distributing costs in a way that subsidizes those who are less able to afford the services.

² The Economics of the Social Economy, Carlo Borzaga, 2000

The involvement of multiple stakeholders also limits the monopoly market control of government services and the attendant problems in the transmission of preferences by users.

Co-ops are better suited to the production of **relational goods** in which the involvement of the consumer is integral to the service being provided. This is especially the case in services like employment training or health care in which the proper delivery of a service requires the direct involvement of the consumer. The specialization of services that are required for the training and employment of people with disabilities for example is far more efficient when consumers are involved. The labour integration services of social co-ops address the failures of both government and the market because of the control rights assigned to consumers with special needs (see Part Three – Social Co-ops, Disadvantaged Workers and the Labour Market).

Since social co-ops are not as limited in the distribution of profits as conventional non-profits, they are better equipped to raise capital from members, funders, and other stakeholders. They are also able to provide a limited return on invested capital to investors and funders. These capital advantages make social co-ops more entrepreneurial and more able to finance innovation in service delivery or the development of new projects.

These advantages of co-ops to more conventional forms of service delivery are however, counterbalanced to some degree by the disadvantages of higher transaction costs due to more complex decision making processes and a lesser capacity to attract charitable donations (in the case of non charitable co-ops). Of course, the focus on social goods and member service as opposed to profit restricts co-op access to private investment capital that is the lifeblood of for-profit firms.

As will be outlined below, the government policies that are used to promote this model in Italy are central to the success of social co-ops in that country. They hold important lessons for the adoption of similar models in Canada. In the case of health care, the example of Japan and the recent history and experience of health co-ops in BC provide some indication of the opportunities, and obstacles, to the expansion of co-operative models of health delivery in this province.

Part Two – Health Care Co-ops

Health Co-operatives – Japan’s Health Service Alternative

Japan presents one of the world’s most advanced examples of the use of co-operatives for the provision of health care services on a large scale.

Currently, over 120 health co-operatives operate in Japan, serving nearly three million members. Founded on a health promotion philosophy that remains at the heart of Japan’s health co-op movement, the health co-operatives of Japan operate major hospitals, community clinics, senior’s facilities, long term care facilities, and home care programs. Japan’s health co-ops train and certify doctors, nurses, and other health professionals and have developed a sophisticated health promotion strategy involving a vast network of community health groups called “Han” which work closely with local hospitals and clinics to link health professionals with the work of community health volunteers.

Volunteers play a crucial role in the overall functioning of the co-op system as they are trained to undertake a range of regular community health checks involving tests for individuals’ blood pressure, weight, muscle mass, stool and urine analysis, and diabetes. The results collected in this way are passed to a professional at a health co-op for further analysis and prompt follow up if required.

This use of a committed and engaged group of health volunteers helps to keep the operating costs of health promotion down while keeping a close watch on evolving health issues as they emerge in a particular community. In turn, community involvement in the delivery of local health and social services

strengthens relations between health providers and community members while building strong social bonds among community members.

The social networking among community members around the issue of health promotion is not peripheral to the co-op health system. It is at its heart, binding the operations of the health co-ops to the conscious efforts of community volunteers to strengthen social networks as a key determinant of personal and community health.

This community-based health promotion strategy has yielded impressive results on reducing the gap between disease diagnosis and treatment, on shortening the length of hospitalization, and on the ability of outpatients to return to their homes after initial treatment. In one typical Geriatric Health Service Co-op the average length of stay is 109 days. The home return rate among patients at age 85 years or older is an astonishing 45%. Meanwhile, the annual membership cost for use of the co-op's services is \$60. The monthly cost for users staying at the facility is about \$500, which is covered by a combination of the users' pension plan and a user fee.³

As in Canada, Japan's health policies have been affected by government cutbacks and by changes to tax policy that have reduced the corporate share of income tax from what it was 25 years ago. The shift of the tax burden to individuals and to the middle class has also been accompanied by gradual increases in user fees.

These changes have meant that the funding of health care in Japan is being borne by those segments of society less able to afford it while user fees are disproportionately affecting the poor. For this reason, many health co-ops refuse to discriminate between patients on the basis of ability to pay, thus allowing equal access to the co-op's services to all community members.

Universal health insurance was introduced in Japan over 50 years ago. And despite these recent policy shifts, Japan's health and social security programs provide the primary source of funding for health services whether through public, private, or co-operative delivery systems.

There are three major health plans covering the health costs of Japanese citizens. At the federal level, the public health insurance system covers 150 million Japanese, with most of the insured being government employees and their families. The second largest provider is the municipal government plan and this covers the self-employed, the elderly, and the unemployed. The third largest providers are the employer insurance plans established by companies for their employees.⁴

Currently, those under 70 years of age and their families must pay 30% of insured health costs. Beginning in 2008, those over the age of 70 will have to pay 20% of costs, up from 10%. Because Japan's population is among the world's most aged, these programs are central to the provision of health services to the elderly and seniors constitute the largest portion of health consumers in the country, including for health co-ops.

Tokyo Health Co-operative

Tokyo Health Co-operative provides services in six wards of the city and operates two hospitals and ten clinics. The clinics are elder care facilities and each clinic employs a full-time physician. The hospitals are owned and governed by the co-op members. As mentioned above, the focus of the co-op is on health promotion and preventative care.

³ Kawashita Geriatric Health Services Facility, presentation October 2007

⁴ Presentation, Japan Health Co-op Study Tour, 2007

Tokyo Health Co-op has 45,000 members and holds around 1.9 B Yen in shared capital. In addition to the main hospitals and community clinics the co-op has 39 branches and employs 550 full-time and 500 part-time employees. The co-op's physicians are on salary, as are all doctors working in Japan's health system. Unlike other hospitals, co-op members pay no fees for services that are not covered by Japan's medical health system. And unlike state and privately run health services, Tokyo Health Co-op maintains high quality standards for patient care despite the absence of additional user fees. Service accessibility and affordability remain central to the co-op's mission.

However, this focus on the widest possible access to care is being challenged by pressures relating primarily to the cost of skyrocketing real estate in Tokyo (\$9,500 per sq. meter) and changing government policy on health insurance and pension plans that now call for increasing user payments. Here again, the co-op's links to community *Han* are essential to the provision of health services. The Tokyo Health Co-op, like other co-op hospitals, relies on member investments and community fundraising to expand facilities, hire staff, and acquire new equipment.⁵

The Ottizumi Health Co-op hospital in Tokyo is a case in point. The hospital was built in 2002, has 150 employees and has a membership of 45,000 that pay a membership fee of \$10 dollars. Community fundraising raised the funds to cover the co-op's capital investments and equipment purchases. The co-op is also paying off a bank loan to cover a \$1M annual operating deficit.

Like other health co-ops, the co-op's health services are covered by a combination of government subsidies and user fees with 70% of treatment costs covered by government insurance plans and the balance by user fees.

Similarly, the *Nagano Central Hospital* of *Nagano Health Co-op* started in 1961 as a small clinic with one nurse and one administrator. In 1966 the co-op mobilized its 600 members to raise 50% of the capital needed to build a new hospital with the remaining 50% provided by a bank loan. Today the co-op has 47,000 members, 31 branches, and a partnership with 376 Han groups that carry out the co-op's community health and fundraising activities.

Japan's health co-ops are modeling a health approach that blends public funding of health care with community control exercised through the health co-ops operating at the community level. The co-operative aspect of health promotion and disease prevention is intimately tied up with a conscious community building strategy that focuses on building social bonds through the promotion of community health.

This combination of public funding, user control, and community mobilization has created an environment in which local residents and health professionals exercise control over primary health care in a way that rewards innovation and accountability without compromising the role of the State in health care funding and regulation.

In short, Japan's health co-ops have played a central role in realigning the roles of the state and the social economy in the area of health care. And despite the absence of appropriate legislation to regulate co-operatives and non-profits in the country (there is no overarching legislation for co-ops in Japan - each sector has its own co-op legislation) and the fact that non-profits are not recognized in the country's tax policies, the mobilization of community in the work of health promotion has made possible the remarkable achievements of Japan's health co-op system.

This is perhaps the most important lesson for policy reform to be drawn from the Japanese experience.

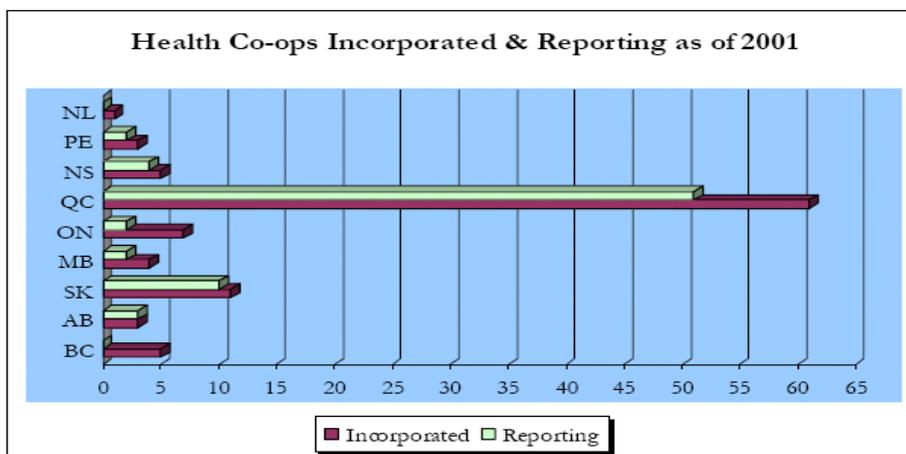
⁵ ibid

Health Co-ops in Canada

Health co-operatives first emerged in Canada in the early 1940s, in the province of Quebec. A definition used in Quebec described a health co-operative as "a private, voluntary organization free of political influence and made up of individuals working together to obtain medical services. The organization is based on four principles: team-based medical practice; preventive medicine; periodic payment; and consumer control."⁶ These principles are fundamental to almost all health co-op models and as shown above, reflect the central philosophy of health care co-operatives in Japan.

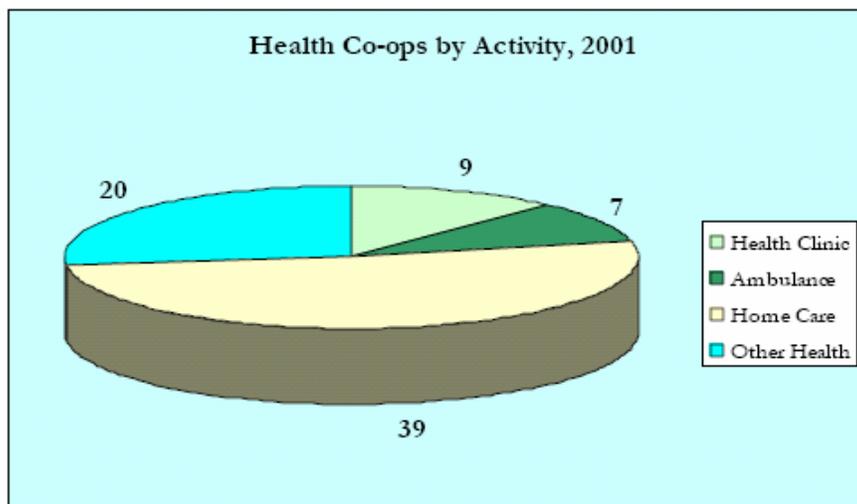
The first health care co-op in Canada, *Coopérative de santé de Québec* was incorporated in 1944 in Québec, followed by *C.U.&C. Health Services Society* in 1946 in British Columbia. But it wasn't until the doctor's strike organized to fight the introduction of Medicare in 1962 that health co-ops became widespread in Saskatchewan and elsewhere as a means of organizing health care at a community level.

The following diagram illustrates the number of active health co-ops in Canada.



Source: Craddock and Naila (2004), p.2

This diagram illustrates the type of activity that health co-ops engage in.



Source: Craddock and Naila (2004), p.3

⁶ http://www.coop.gc.ca/index_e.php?s1=pub&page=health-sante, Accessed: April 21st, 2008.

The following table offers a comparison of health co-ops according to type of activity between 1997 and 2001.

Table 1: Number of Health Co-ops Reporting, 1997 – 2001

	1997	1998	1999	2000	2001
Health Clinic	12	11	11	11	9
Ambulance	7	6	6	6	7
Home Care	3	7	18	32	39
Other Health	13	18	20	22	20
Total	35	42	55	71	75

Source: Craddock and Naila (2004), p.3

It can be seen that although the number of health co-op clinics has declined over the years there has been significant growth in home care as well as other health related co-ops. The majority of home care co-ops during this period emerged in Québec as a result of supportive government policies that included a financial relief program for users of home care services.

Table 2 offers a brief overview of Home Care Co-ops in Canada:

Table 2: Home Care Co-ops Reporting, 1997 – 2001

	1997	1998	1999	2000	2001
Number	3	7	18	32	39
Total Membership	312	776	3,258	6,661	15,137
Total Employees	61	227	502	794	1,251
Total Revenues (million \$)	1.5	2.7	6.3	13.5	20.2
Total Assets (million \$)	0.3	0.9	2.0	3.8	7.4

Source: Craddock and Naila (2004), p.4

The case of Quebec is unique with respect to the funding of home care co-ops. Since 1997, the Quebec government has provided state support to the development of homecare co-ops by creating two sources of funding for these services.

The first is a grant of up to \$40,000 provided for the creation of a Homecare Social Economy Enterprise (HSEE). The second is the *Programme d'exonération financière en services à domicile* (PEFSAD), which contributes a portion of home care costs incurred by a recipient of these services. The combination of these two programs, along with the legislative recognition of solidarity co-ops in 1997, has led to a flourishing of the co-op model for the provision of home care services for seniors (and others) in that province (see section on Social Co-ops below).

The support of provincial policies for co-operative and non-profit models of home care and health related services in Quebec is an object lesson on how enabling policy can improve the use of community based models for health care. In effect, the willingness of government to cover the gap between the cost of home care service and what is payable by consumers has helped home care co-ops flourish inside the province.

As in Japan, Quebec's policies have created an alternative and complementary model for health care. Moreover, Quebec legislation has recognized the specific role of "solidarity co-ops" as a key source of home care services organized at a local level.

However, current Canadian data on the comparative performance of health co-ops on such diverse issues as access to services, waiting lists, cost of care, hospitalization rates, and employee and patient satisfaction is not available. The last report to research these issues was by Angus and Manga in 1990⁷ and showed that co-operatives, along with other community based health care models, lowered the rates of hospitalization, encouraged preventative care, significantly reduced drug costs, and delivered a higher quality of service than other models of health delivery.

Despite the documented benefits there continues to be a lack of information on health co-operatives and their impact on health care services.

Co-operative Health Care in British Columbia

Co-operatives offer a viable and cost effective means of providing health and social care services from the evidence gathered both in Canada and abroad. However, despite the evident interest on the part of many communities to adopt a co-op approach to health care, the growth of health and social co-ops in British Columbia province has been slow.

What are the obstacles and challenges holding back the development of these co-ops in BC?

To answer this question, interviews were conducted with health co-operatives currently active in British Columbia as well as with co-op developers active in this field.

The following co-operatives were surveyed:

Care Connection Co-op, Mission, BC

Community First Health Co-op, Nelson, BC

Pacific Rim Health Services Co-op, Port Alberni, BC

Alberni Valley and Housing Health Care Co-op, Port Alberni, BC

Health Services Co-op and First Senior Village, Golden and District, BC

Kootenay Lake Eastshore Elder Care Co-op

Barriers to the Development of Health Co-ops in BC

According to Sinats (2001)⁸, the following are key barriers that health co-ops face in British Columbia:

- General lack of knowledge and awareness about the co-op model
- Poor evaluation procedures of the health co-ops on their performance
- Difficulty of obtaining health professionals to work in co-op hospitals and clinics
- Absence of legislated legitimacy

⁷ Douglas Angus and Pran Manga, 1990, "Co-op/consumer sponsored health care delivery effectiveness."

⁸ Sinats, Kristen. 2001. "Health Co-operatives: A viable Solution to the Current Crisis in Health Service Delivery".

British Columbia Institute for Co-operative Studies. University of Victoria. Occasional Papers, Number 5

The survey of health care co-operatives in British Columbia discovered additional barriers to the development and operation of health co-ops than those mentioned by Sinats. These are outlined below.

Labour Related Challenges

Many doctors prefer to be self-employed and compete directly with health co-ops for the delivery of services. Self-employed doctors start their own clinics and collect fees for services rather than work for a salary as is the case in many (but not all) health co-ops.

One response to this challenge is for health co-ops to attract health professionals immigrating to Canada in search of employment. This was the strategy adopted by the Multicultural Health Brokers Co-operative in Edmonton. The co-op offers pregnancy and after childhood services to immigrant families in more than 14 languages and since 1995 it has provided support to over 8,000 immigrant and refugee families.

Indeed, this was the strategy that was used to great effect by the health co-ops of Saskatchewan when they responded to the doctors strike in 1962 by recruiting physicians from the U.K. to staff their clinics.

If a key limiting factor of health co-ops is related to labour supply, an additional strategy is to recruit aspiring health practitioners and integrate them into the health co-ops by offering them an opportunity to provide their services during the residency period.

There are however, examples of health co-ops in British Columbia that did not experience labour shortage issues and where the demand for health services enabled the co-ops to successfully provide them. For example, *Community First Health Co-op* in Nelson owns and operates a building with 15 tenants including health practitioners, who offer a range of health related services to the community.

Pacific Rim Health Services Co-op in Port Alberni operates a family medical clinic, and two doctors were prepared to offer their services even before the health co-op was formed. Currently, there are four doctors offering their services: two general practitioners, one surgeon and a dentist. In the summer another general practitioner is expected to arrive.

Community Involvement and Co-op Membership

Another challenge that health co-ops face stems from the difficulty of mobilizing community involvement. Community involvement is vital to the co-operative model and the need for an engaged citizenry is a challenge not faced by conventional forms of health service delivery.

The success of health co-ops is directly related to an active membership and the broader involvement and engagement of community members both in the development phase of the health co-op and its delivery of services. *Pacific Rim Health Services Co-operative* is a multi-stakeholder co-op with around 100 members. They are comprised of six local organizations, the co-op doctors, 10 founding members and individual community members. Volunteer help and community involvement has been a central factor in both the development and operation of the co-op.

A second co-op operating in Port Alberni, *Alberni Valley and Housing Health Care Co-op*, is also a multi stakeholder co-op comprised of three organizations and two individuals. The co-op operates 26 assisted living units in the community and a waiting list is already in place due to a huge interest in the services that the co-op offers to members.

Community First Health Co-op in Nelson has about 1,500 members and the value of the co-op's assets has surpassed one million dollars. The founding members comprise about 60 per cent of the membership

and as in Port Alberni, the community involvement and support of volunteers from across Nelson has been central to the co-op's success.

The Kootney Lake East Shore Elder Care Co-op, which is still in the development stages, already has 180 committed members. This multi-stakeholder co-op is the largest organization on the East Shore of the Kootney Lake.

Finally, widespread community outreach and education, physician support, and the support of numerous community organizations has been the foundation for the incorporation of the *Victoria Community Health Co-op*, the most recent health co-op to incorporate in BC.

Lack of Knowledge and Evaluation Procedures

Sinats (2001) argues that policy makers need to be educated about the benefits of the co-op model for health and social services. The role of umbrella associations representing the co-op sector at both the federal and provincial level is key to making the co-op case.

In the past, the Canadian Co-operative Association (CCA) as well as the British Columbia Co-operative Association (BCCA) have been successful in affecting public policy. BCCA helped develop changes in legislation to increase support of co-operatives, including the recognition of community service co-ops as non-profit co-ops with a mandate suited to the provision of health and social care services to communities and special needs populations.

However, a more concerted strategy involving the mobilization of health and social co-ops along with other supportive organizations is required to press the case for co-ops among politicians and policy makers at both the ministry and health authority levels.

This strategy needs to be linked to more careful documentation of co-op services and operations. In order to further support the development of health co-ops, evaluation systems and techniques need to be developed to track the performance of health co-ops as part of the effort to establish their legitimacy. Careful evaluation of health co-op practices will help build a proof of record and performance in the provision of health services. Data collection and record keeping systems should be established to track services, measure patient satisfaction, and assess cost effectiveness both to the health consumer and to the taxpayer.

Procurement Practices and Requests for Proposals

The procurement practices of the provincial government are a major obstacle for health co-ops in British Columbia. Since the most recent restructuring of BC's health system, government requests for proposals (RFPs) have been awarded primarily to private providers. One result of this process is that the principles of "social tendering", which includes support for community-based service and recognition of health co-ops as viable providers of health care, have not been taken into account by the health care authorities.

Based on the empirical evidence experienced by health co-ops and the operational procedures of the Regional Health Authorities, it may be argued that the RFP process currently in use discriminates against health co-ops.

RFPs are structured to fulfill large contracts for the Regional Health Authorities. Because health co-ops operate on a much smaller scale they are less able to bid on RFPs due to their financial constraints. Their recent arrival on the health care scene also means health co-ops lack a proven track record in the province.

One option for addressing an RFP bias favouring large operators is to “unbundle” contract services and offer health co-ops an opportunity to bid on a smaller scale of services until an evaluation of the health co-op’s operations, costs and quality of service over the long term can be established.

The unbundling of RFPs would require government agencies to “break-up” large RFPs and assign parts of large contracts to smaller community based health care providers, rather than a sole corporate provider. Designing policies to modify current RFPs by including “social tendering” regulations would enable smaller providers like health co-ops to attain a proof of record and secure a source of revenue while promoting, and testing, the comparative value of community based health services.

The BC government is not paying attention to the co-op model. The approach adopted by health authorities favours service delivery by large providers. The role of smaller scale, community based services is not a model that is well understood or supported by the BC health system. The experience of those co-ops that have attempted to bid on the delivery of health services has given little reason for optimism.

The Health Services Co-op in Golden is one example. For many people, the main issue in Golden was that health policies are designed for an urban environment while Golden is situated in a rural community where the issues are different from those of an urban centre. The same can be said for health policies with respect to rural communities in general.

For example, the Interior Health Authority operates 8 unit assisted living housing in Golden. Despite a growing need for more assisted living units at an affordable price, the IHA made a decision not to expand assisted housing to 20-30 units that would better meet the needs of the community. With rising costs of living, and the increasing difficulty of seniors to remain in their community, it remains unclear why a decision was made not to increase the assisted housing capacity in Golden.

The Health Services Co-op in Golden is trying to complete is a 55-unit senior housing development, *First Senior Village*, which would offer blended care services to residents. In-house services are planned to start as soon as staff and the stability of the housing project is established. With a zero percent vacancy rate in Golden the *Health Services Co-op* is trying to address the acute shortage of senior housing in the community. The development of *First Senior Village* has taken 3 years so far and according to the co-op developers, progress has been hampered by the unwillingness of the Interior Health Authority to cooperate by providing financial and logistical support for the development of this assisted living facility. The co-op’s experience to date has been that government has been neither helpful nor supportive of this community initiative.

As mentioned above, government procurement policies for health services require that providers have a proven record of operation. When *Health Services Co-op* submitted a bid to a government RFP for the operation and management of the assisted living units, BC Housing and the Interior Health Authority rejected the proposal on the basis that the co-op had no track record in running and managing a similar project. Lack of experienced staff was also cited as a factor. The rationale for the rejection seems reasonable. But *Health Services Co-op* in Golden was not the only co-op whose proposals have been rejected.

Care Connection Co-op is a worker co-op in Mission whose members share over 50 years of professional care experience between them. The home care services provided by the co-op “include personal care, companionship and homemaking with specialized forms of care that help people remain independent in a safer and healthier home environment”.

When *Care Connection Co-op* approached the Fraser Health Authority and submitted their proposal for home support services, the health authority manager struggled with the idea of splitting the RFP in order

to enable *Care Connection Co-op* to provide a contracted service. In the end, *Care Connection* did not get the contract since the co-op did not have a record of operation and was new to the industry, despite the extensive experience of its members. The Fraser Health Authority awarded the contract to a single agency that has since struggled to meet the demands of its customers. The contracted provider now refers a number of its patients to *Care Connection* so that it can meet the demand.⁹

In some cases, the argument for a proven track record has been used to select providers with questionable records of service over community-based co-ops. *Community First Health Co-op* in Nelson has repeatedly tried, and failed, to secure service contracts for the management of long term care facilities in Nelson.

The first attempt to bid on a government contract was turned down by the Interior Health Authority because of the co-op's lack of a track record. Instead, the contract was awarded to a private provider with a record of poor service. Fed up and frustrated with the manner in which the Interior Health Authority handled the RFP process, *Community First Health Co-op* did not attempt to bid on further contracts but pursued the development of a wellness center with the help of the BC Housing and Mortgage Corporation and the support of local organizations, most notably the Nelson and District Credit Union. The center has now opened and provides co-op members and the community with access to a wide range of health services under one roof.

Pollack (2006) also acknowledges the experience of *Community First Health Co-op* in dealing with the health authority. According to Pollack the co-op presented a solid bid but the health authority awarded the contract to a private operator with a record of non-compliance at its private-pay health care facility in Nelson. Pollack also pointed out that the standards of health care services delivered by the private company did not meet the needs of the community. The quality of health services delivered by the private provider suffered due to a lack of staff and a lack of quality training.

Barbara Stevenson from *Port Alberni Health Co-op* has also pointed out that the regional health authority prefers to contract with private providers for health services. Again, the reason attributed to the government's preference for private providers is their ability to service large single source contracts.

The *Alberni Valley and Housing Health Care Co-op* in Port Alberni currently operates 26 units used by the seniors and provides assisted living services. The units are owned by the society and all the units provide assisted living arrangements. All the units were occupied in the first two weeks of their operation and a waiting list is already in place.

Lack of start-up capital

Lack of financial capital to develop and sustain a health co-op during the initial years of operations was mentioned by almost all of the health co-ops in BC as a major obstacle.

Like most co-ops, health co-ops issue member shares to assist in the capitalization of the service. However, given the high start-up costs associated with the provision of health care, co-op shares alone are not sufficient to cover the service costs. And although some programs provide financial support for co-ops at the developmental and organizing stage (e.g. The Co-op Development Initiative (CDI)), there are no funds available for longer-term capitalization and operational costs.

Karen Smedley from *Health Services Co-op* and *First Senior Village* in Golden acknowledged that the CDI program is a support, but it can be used for development work only. The project in Golden required

⁹ Interview with Laura Rath, 2008

major financial support from The Columbia Basin Trust to get off the ground. The Columbia Valley Credit Union also helped to finance the project.

Other health co-ops that received financial help through a CDI grant along with technical assistance from the BC Co-op Association include *Port Alberni Health Co-op*, *Pacific Rim Health Co-op*, *Community First Health Co-op*, *Victoria Community Health Co-op*, and *Care Connection* in Mission. In the case of *Care Connection*, it has taken five years for the co-op to break even.

Volunteer Support and Managerial Expertise

One of the biggest challenges for *Health Services Co-op* and *First Senior Village* in Golden has been the huge demands placed on the volunteer board. This reliance on volunteer effort is both a strength and weakness of co-operatives as member controlled organizations. And, while volunteer effort is central to the start up and success of a co-op project, it is also essential that entrepreneurial and managerial expertise is available to transition a co-op from a development project to a successful enterprise.

This issue was mentioned during the interview with the co-op and the point was raised that the project needed an entrepreneurial person to drive the initiative ahead. Despite the co-op's social mission and their community ownership, co-ops need to remain economically viable to deliver services and meet the needs of community members. Sometimes, the drive that is motivated by the co-op's social mission doesn't always attract the type of individual with the expertise that is needed to transform this social mission into a successful enterprise. What is needed is the kind of leadership that blends social vision with entrepreneurial skill. This is hard to find, particularly in an environment where health and social co-ops remain a novelty.

What often holds back the development of health co-ops is the narrow membership and population size in small rural communities such as Golden or Kootenay Lake East Shore. A small population limits not only the available pool of volunteers, but increases the challenge of building a strong membership base and raising the start-up capital for the project.

Summary of Barriers and Potential Remedies

The following barriers sum up the primary difficulties encountered by health co-ops as they struggle to develop a co-op health service alternative in BC.

- General lack of knowledge about the co-op model
- Lack of targeted marketing strategy and promotion of the co-op model
- Lack of evaluation procedures for the performance of health care co-ops
- Lack of a proven track record of operation
- Challenge of recruiting health care professionals
- Lack of community involvement and small membership base
- Preference for large scale, single source procurement practices by regional health authorities
- Lack of start-up capital
- Challenges of volunteer boards

To counter these difficulties, a number of policies need to be adopted by government agencies and the co-op sector itself if health co-ops are to meet their potential as a community health care model for BC.

Enabling Policies and Remedies

- The benefits of the co-op model should be clearly communicated and presented to the provincial government and the regional health authorities by national and provincial co-op bodies.
- Marketing strategies focusing on the benefits of co-op models for health care should be carried out by national and regional co-op associations in collaboration with health co-ops and other supportive stakeholders.
- Health care co-ops should develop an effective means to evaluate and measure performance. Effective evaluation can help health co-ops establish legitimacy, generate a proven track record and further enhance the chances of winning government contracts.
- Health co-ops should target emerging health care professionals, and health care practitioners relocating to Canada for recruitment as well as former health care employees that lost employment due to government cuts or public sector restructuring. Additionally, health co-ops can apply strategies used by groups such as *St. Etienne de Gres Health Co-op* in Ontario to attract health professionals by developing a suite of support services to health providers that enable them to practice without the additional burden of administration and overhead costs associated with private delivery.
- Government procurement practices and requests for proposals should include a social tendering provision that reserves a portion of government health care contracts to community initiatives, co-operatives and non-profits.
- Large government contracts should be “unbundled” to enable community-based programs and new co-op projects to establish a proven record, build local expertise, and develop legitimacy in provision of health and social care services.
- A community health funding program should be established to generate a range of financing tools for community health co-ops and other non-profit health initiatives operating at a community level. These should include a combination of grants, low cost loans, and capital raising tools such as community bonds and social investment shares.
- Start up funding up to 50,000 should be established as part of a program for the development of community-based health co-ops.
- The province should seek health funding partnerships with foundations, private institutions and local credit unions for the development of new projects with a community health focus.
- Drawing on the successful lessons of Quebec, the province should examine the use of tax and policy instruments such as those used for the creation of Homecare Social Economy Enterprises (HSEE), and the *Programme d'exonération financière en services à domicile* (PEFSAD), for the provision of home care and other health support services through co-ops and non-profits.
- In general, community-based health care and the role of consumer run health services should be incorporated as a key element in the province’s overall health strategy.
- A formal assessment of the benefits, challenges and requirements of community-based care in BC should be undertaken by the Ministry of Health and the Regional Health Authorities in partnership with stakeholders in the co-op and community health sector.

Part Three - Social Co-operatives

The Social Co-op Phenomenon in Italy

Social co-operatives were pioneered in Italy, where the debate concerning the role of the state has raged as it has in all the western democracies. But the outcomes have been more diverse.

In Italy, there has emerged a model of social co-operatives that places civil society at the forefront of social service reform. Here, social co-operatives are inventing models of care that are advancing social economy values as a clear alternative to both state and market systems.

Social co-operatives in Italy rose autonomously, largely from voluntary organizations, to compensate for the inadequacies of the Italian welfare system and as an expression of the renewed vitality of civil society. They were not, as some have claimed, an outcome of state decentralization or outsourcing.

The results of this movement have been profound, and the effects are being felt throughout Europe and increasingly, in North America.

First organized in the early 1980s, social co-ops were formed by caregivers and families of people with disabilities to provide services to the disabled that were not available from the state. Along with the explosive growth of non-profit associations during this period, the activity of these co-operatives resulted in their formal recognition in Italian legislation in 1991 (Law 381/91).

In Italy, there are now more than 6,000 social co-operatives providing social services throughout the country. Social co-ops employ 60,000 individuals, of whom 15,000 are disadvantaged workers. Social co-operatives employ fully 23% of the non-profit sector's total paid labour force, even though they represent only 2% of non-profit organizations.

A telling feature of the Italian social co-ops is the measure of job satisfaction reported by workers.

By comparison to their counterparts in the public sector, workers in social co-ops are more satisfied with job quality and the overall employment environment, including their perception of their work as an important source of self-fulfillment. This job satisfaction is directly related to the belief that they work in an environment of shared values and that they are decision-makers in the design and delivery of the co-operative's services.¹⁰

Professional training and career advancement is also an area where workers employed in social co-ops report higher levels of satisfaction than their counterparts in the public and private sectors. Employee turnover in social co-ops is the lowest among the three.

On the other hand, despite relatively high levels of job satisfaction the comparatively lower rates of pay for non-managerial positions have been an issue in the sector and a cause of concern for the public sector unions who have interpreted this disparity as a downward pressure on wage rates in the public sector.

Similarly, the use of volunteers to augment the services delivered by social co-ops and to keep operational costs down has been a source of friction with some unions who see the practice as constricting the job

¹⁰ Borzaga, 2000

market and compromising work conditions and standards. The vast majority of workers in social co-operatives is unionized or is represented by established trade unions.¹¹

Today, the economic turnover of the social co-operatives accounts for 13% of the Italian state's expenditure for social services. In the city of Bologna, over 87% of that city's social services are provided through social co-ops under contract to the municipality.

Definition & Types of Social Co-operative

As described in Law 381, social co-ops have as their purpose

“To pursue the general community interest in promoting human concerns and the integration of citizens”.¹²

In this sense, social co-operatives are recognized as having goals that promote benefits to the community and its citizens, rather than maximizing benefits solely to co-op members. Moreover, Italian legislation acknowledges the affinity between public bodies and social co-ops in the promotion of public welfare, and emphasizes the possibility of collaboration between them.

For this reason, many social co-ops receive public funding in the form of operating subsidies that offset labour costs and also enjoy greater flexibility than other forms of enterprise in the application of labour legislation.

There are two types of social co-ops:

Type A, which provide the delivery of social, health, educational, and recreational services, and

Type B, which provide for the gainful employment of the disadvantaged through training in the agricultural, industrial, business, or service sectors.

Type B social co-ops must have at least 30% of their employees drawn from marginalized and disadvantaged groups which include the handicapped, the elderly, youth, people with intellectual handicaps, and such excluded groups as prisoners, ex prisoners, minors at risk, and drug addicts.

All these groups are clearly recognized in the social co-op legislation. Italian legislation also allows Type B social co-ops to be exempted from paying mandatory payroll costs as the state picks up this cost as an incentive to promote the hiring of people with employment barriers.

A further development in the treatment of social co-operatives has to do with membership. Italian law now provides that the ownership structure of social co-ops may be comprised of several categories of members (workers, users, volunteers, investors, and public bodies), all of who have an interest in the production of the service.

This multi-stakeholder aspect has figured prominently in the evolution of social co-ops to pursue more public and less mutualistic aims. It also reflects the expanding focus on community service as opposed to the traditional co-op focus on member benefit.

¹¹ Note: Italian labour legislation allows for workers to be represented by unions regardless of whether they are trade union members.

¹² Restakis (2006), p. 3

As outlined above, these new organizations rely far more on the broader representation of stakeholder interests and on participative and democratic management than they do on the traditional constraint on the distribution of profit typical of traditional non-profits.

The experience of social co-operatives in Italy has led to a radical rethinking of how the public interest might best be served by entities other than the state. Nevertheless, social co-ops in Italy are not seen as a *replacement* of public sector services. Rather, they are viewed as a means by which civil society can *complement* the provision of services to citizens while maintaining the essential role of the state as both funder and guarantor of social care.

Moreover, the regional government in Emilia Romagna has introduced policies that promote the use of social co-ops for the provision of social care to the region's most vulnerable individuals.

These include:

- Exemption of social co-ops from mandated employer costs such as unemployment insurance, pension payments, and health benefits if the co-op employs more than 30% of its workforce from disadvantaged populations;
- Restriction for the provision of services such as social care, childcare, education, and senior care to social co-ops and non-profits;
- Recognition of employment in social co-ops as an alternative mechanism for the rehabilitation of offenders.

Social co-operatives in Italy constitute a well-organized and highly mobilized sector within the social economy. Social co-ops belong to regional and sector consortia that provide direct services to member co-ops in the form of technical assistance, training, information sharing, and the preparation of bids for tender. At a national level, social co-op federations engage directly with the national and regional governments on such issues as funding levels, quality standards, evaluation of services, service priorities, state oversight and regulation, and contractual relations.

This engagement with the state on service design and delivery also necessitates an essential political role with regard to public policy. Leaders in the social co-op movement feel that the future role of social co-ops is not only to provide an alternative system of social care. It is also to monitor the role of the state vis-à-vis its support of public services, and to hold the state accountable for the provision of these services to the public. In this area in particular, social co-ops have a particularly strong interest insofar as public funding is central to their functioning.

The social institutions that have been built up to support the operation of social co-ops also constitute an effective counterweight to the role of the state.

Social Co-ops and Social Inclusion

“Society widely recognizes that many people with disabilities can gain both socially and economically from participation in the labour market. That’s true not only because of the obvious link between economic security and employment, but also because of the understandable connection between well-being, self-esteem and meaningful employment.”

Marcy Cohen and others (2008)

As outlined in the opening section of this report, the use of co-op models for the provision of social care to marginalized people has become one of the most important innovations in the co-op model in recent decades, particularly in Europe, but also increasingly in Canada and especially in Quebec.

This section deals predominantly with social co-ops whose primary purpose is to serve marginalized populations and to integrate them into the labour market through employment training and job placement. As described above, these are Type B social co-ops in Italian legislation.

The economic data on 528 co-operatives provide insight into the performance of social co-operatives in Italy.

Average annual turnover per co-operative was around 400,000 ECU in 1994. The majority of earnings came from the sale of goods and services (86.7%), while the public and private grants represented only about 13.3% of revenues. These figures reveal that social co-ops in Italy are financially and operationally sustainable, with only a small part of their budgets coming from outside funding or grants. Grants and external funding are used as a supplementary source of financing rather than a sole source of income.

From a public policy point of view, social co-ops require less of taxpayers' money to supply services as they are capable of generating revenue rather than being reliant solely on public funds for their operations. Further, social co-ops are capable of providing employment opportunities for those who would otherwise be dependent on income assistance. This labour integration function frees up additional public resources by reducing dependence on state welfare programs, increasing disposable income and living standards of persons with disabilities (PWD) and persons with persistent and multiple barriers to employment (PPBM), and greatly increasing the self-esteem and self-reliance of these individuals.

The goods and services produced by the Italian co-ops were sold mainly to the public authorities (57.7%) while private users purchased around 29% of the services. The average size of an Italian social co-op is between 40 to 50 members and 25 paid workers (mainly members). The vast majority of co-ops (about 90%) have fewer than 100 members and about 70% of co-ops have fewer than 50 members, while only few very large co-ops can be found.

“Under pressure from the demand for social services, local authorities increasingly began to contract out these services, particularly the most recent ones, to social enterprises. This trend made it possible for public authorities to increase the supply of services without boosting the number of civil servants and it was at odds with the previous model, which allocated even the production of services to the public administration.”¹³

As mentioned above, Quebec provides a Canadian example for the use of social co-ops as a model for the delivery of services to vulnerable populations. Like many of the social co-ops in Italy, the Solidarity Co-ops of Quebec use a multi stakeholder structure to deliver home care services to seniors and people with disabilities. And as in Italy, provincial policies support the use of these co-op and non-profit models through tax support, public policy and legislation.

Since 1997, the growth of solidarity co-operatives in Quebec has introduced a major innovation in the organizational make-up of social enterprises serving seniors in the province. Under the HSEE model described above (page 10), there are now 103 enterprises providing home care services in Quebec of which 61 are non-profit organizations and 42 are co-operatives. Most homecare co-ops have adopted the solidarity co-op structure. The remainder is consumer co-ops.

To gain a clearer picture of the types of services offered by the Solidarity co-ops, the following is a listing of services offered by *Homecare Services Co-operative of Estrie* as described in a 2005 pamphlet.

¹³ Borzaga & Santuari (2000), p. 28

Services offered by the Homecare Services Co-operative of Estrie

Services	Description
Light housekeeping	Dusting, vacuuming, change of bed sheets, etc.
Heavy housekeeping □(Spring Cleaning)	Cleaning inside cupboards and closets, washing windows, cleaning furniture
Clothing care	Washing and ironing of clothing
Preparation of meals	Cooking of meals on a daily basis, preparation of frozen meals
Provisions and supplies	Shopping, running errands
Accompaniment □ during outings	Accompanying people during medical appointments or leisure
Monitoring presence□	Keeping company with a person in loss of autonomy so that their natural caregiver can take some time off.

According to data collected over the 2002-2003 period by Jocelyne Chagnon from the *Direction of Cooperatives of the Department of Economic and Regional Development* and from the Research (2004), the 103 HSEE generate sales of 91.7 million dollars and employ more than 6000 people, of which half are full-time.

A little more than 5.5 million hours are sold of which 85% represent independent income. In comparison, these incomes represented 79 % over the 2000-2001 periods, which indicates a relative decline in government funding as a portion of overall costs.

The HSEE are places allowing for the engagement and mobilization of citizens in governance, in particular, decision-making bodies such as the board of directors. Recent work from the *Research Laboratory* on social practices and policies, carried out in 2002 and 2003 by Yves Vaillancourt, François Aubry and Christian Jetté (2003) and Genevieve Langlois (2004), illustrate the potential for innovation by these organizations, their capacity to respond to the needs of the population, and their positive impact with respect to access to services and improvement of working conditions.

Over the 2000-2001/2004-2005 periods, there has been a sizable increase in the size of HSEEs in Quebec:

	<u>2000-2001</u>	<u>2004-2005</u>
Payroll	\$20.3M	\$36.5M
Sales	\$24.4M	\$42.9M
Membership	\$24K	\$38K

Despite this growth the financial resources required to sustain the increased levels and costs of providing services have not kept pace. And despite periodic increases by the province to cover the shortfalls between service costs and users' ability to pay, the financial base of many HSEEs remains precarious.

Disadvantaged Workers and the Labour Market

Social co-ops are a form of social enterprise, and one of their key roles has been to tackle labour market failures for people with disabilities by creating employment opportunities and delivering social services to their members and the broader community.

For this reason, the policies and regulations that surround the treatment of persons with disabilities and persons with persistent and multiple barriers to employment have a strong impact on the degree to which social co-ops are able to play a similar role with respect to disadvantaged populations in this province as they have done in Europe.

Social enterprises are businesses ventures that have a “dual purpose of generating income by selling a product or service in the marketplace and creating a social, environmental or cultural value.”¹⁴ Social co-ops are social enterprises, but all social enterprises are not co-ops. Like social co-ops, they often focus on creating employment opportunities for PWD or for PPBM. Social enterprises provide on-the-job training and supervision while all the support services are utilized to transition people into mainstream employment or to retain these workers and employ them within the social enterprise.

“According to the data supplied by the National Institute for Social Security, which is responsible for insuring disadvantaged people, by the end of the 1996 there were 754 Type B social co-ops employing 11,165 workers, of whom 5,414 were disadvantaged people.”¹⁵ This figure represents about 48.5% of the total workforce comprised of PWD or PPBM. As indicated above, the minimum legal requirement states that 30% of the total numbers of employees in Type B social co-ops must be people designated as marginalized as per the Italian legislation.

A disadvantaged worker can be defined as a worker, given the standard requirements of employers, that is at a disadvantage with respect to the majority of workers. As Borzaga & Santuari (2000) point out, the most common cause of disadvantage is some kind of disability, which can be labeled as a restriction or lack of ability to perform an activity in the manner, or within a range, that is considered normal.

The wider concept of “disadvantage” can be used not only for the disabled people, but also for all the other people who encounter systematic limitations or difficulties in achieving acceptable standards, for example, former drug addicts, ex-prisoners, and individuals with poor or no work related experiences, or the long-term unemployed.

Despite the fact that the presence of physical, mental or other barriers to employment creates a gap in worker’s productivity and performance, in the majority of these cases the gap is neither absolute (that is limitations or gaps in all possible work tasks) nor definite (permanent gaps).

Using this framework, two very different and distinct groups of workers can be found in the labour market:

- a) The individuals whose productivity falls systematically below normal levels in any jobs, regardless of any training (permanent disability)
- b) And the majority consisting of people whose productivity is lower than that of other workers on average, but not in all jobs and/or not definitely (cyclical/temporarily limiting disability).

¹⁴ Enterprising Non-Profits, <http://www.enterprisingnonprofits.ca/>, Accessed: May 20, 2008.

¹⁵ Borzaga & Santuari (2000), p.29

The Situation in British Columbia

The grim reality is that PWD and PPBM are still facing major barriers to employment in BC.

Just over 50 per cent of PWD or PPBM over the age of 25 are in the workforce in comparison to over 80 per cent for people without disabilities. In 2000, 48 per cent of men and a third of women in BC without a disability worked full-time full-year, but only a third of men and less than a quarter of women with a disability worked in BC. Canada-wide, “in 2000 only about 27 per cent of people with developmental disabilities in Canada were employed and 40 per cent have never worked.”¹⁶

Because PWD and PPBM is such a diverse group with a wide range of physical and mental health issues, it is puzzling why the primary focus of governments has been on policies for those who are able to participate in the labour market on an equal footing with non-disabled peers. At the same time, less attention is being paid to those who, given the nature of their disability, may be able to participate only part-time, periodically, or at a level that is below normal productivity levels.

The productivity of workers is a relative determinant of an employee’s contribution to the revenues of an enterprise. Creating employment opportunities that are supportive of people’s individual needs and utilizing their skills, it may well be that the productivity of disabled workers, measured in terms of generation of revenue is at par with the productivity of workers without a disability. When it comes to a performance comparison between a social enterprise and a traditional firm, the performance of some of the social enterprises that currently operate in British Columbia may come as a surprise.

Evidence shows that enterprises that employ PWD or PPBM are capable of providing quality training, supervision, and integration of their employees into the labour force despite the additional costs associated with the training and on-the-job supervision.

Social enterprises create paid employment opportunities for marginalized workers despite the fact these workers face greater barriers to employment than a healthy individual in terms of reduced learning abilities, physical limitations or policies that create disincentives to enter the labour force, such as the 100% clawback on income earned above the \$500 income exception per month. Despite these obstacles, these workers are capable of generating high rates of productivity.

Performance of Social Enterprises in BC

The Cleaning Solution is a contract janitorial company that employs people with mental illness. In the first year of operations in 2005 this social enterprise generated revenue of \$20,000, and approximately \$100,000 in revenues in the following year. The numbers for 2007/08 were under review at the time the report by the Canadian Center for Policy Alternatives was released, but the target has widely exceeded the 2006 estimate of \$35,000. The Cleaning Solution was able to increase their number of workers from 3 to 14 during their first years of operation.

Landscaping With Heart is a social enterprise that employs people with mental illness to provide a range of landscaping and maintenance services. The first year of operation generated revenues of \$250,128, followed by \$423,000 in 2006, with a target of \$541,000 for the 2007/08.

Potluck Café, located in Vancouver’s Downtown East Side, provides training in the catering industry to people with barriers to employment, the long term unemployed, or former addicts. In the first year the Potluck generated \$146,525 in revenues followed by \$672,095 in 2006 with estimates of \$940,800 in 2007/08.

¹⁶ Cohen and others (2008), p. 10

Other social enterprises have also shown a positive growth of revenues, but at a slower rate. For example, **Yards R Us**, a co-operative working in the landscaping and handyman renovations industry, generated \$12,000 in revenues in the first year of operation, followed by revenue of \$ 58,000 in 2006, and a target of \$60,000 for 2007/08.

The Role of Enabling Social Policies

The use of social co-ops and other social enterprises for job creation improves the living standards of PWD and PPMB, while creating social benefits such as reduced demand on social services, health services, and drug and hospitalization costs which flow from an improvement in socio-economic well-being.

The experience of Italian social co-ops and the solidarity co-ops of Quebec show that the right sets of policies can lead to a growth of social co-ops that in turn generate employment, create volunteer opportunities and increase the supply of services for the consumers of social care. There is no question that government policy is central to the growth and long-term viability of both social enterprises and social co-ops.

On the other hand, certain policies can also create barriers and disincentives to the emergence of social enterprises and social co-ops as instruments for the employment of people with disabilities as well as other marginalized groups.

In British Columbia, people who are eligible for income assistance or disability benefits are only allowed to claim an earning exemption of \$500 per month before a 100% clawback takes away income assistance dollar-for-dollar for each dollar earned above the income cap. This policy has been widely criticized as a disincentive for people with disabilities to increase their labour force participation, even though they are capable of doing so without jeopardizing their health conditions.

As a result of this policy, people with disabilities have to limit the number of hour they are prepared to work, regardless of their ability or interest in employment, simply because the income cap threatens the loss of their disability benefits. In addition, this policy keeps these individuals living at below the poverty line in Canada. Cohen (2008) states, “Although PWD benefits are much higher than regular welfare, people receiving PWD benefits still live well below the poverty line. The current benefits in BC of \$906.42 a month are \$554/month below Statistic Canada’s Low Income Cut Off.”¹⁷ Even when PWD do claim the \$500 earning exemption, they still live \$54 dollars below the poverty line.

Given these negative effects, one might ask, “what would be the effect of increasing the income cap”?

Between 2002 and 2006 the income exception in BC increased from \$200 to \$500 dollars per month. The consequence of increasing the earning exemption was as follows:

“The absolute numbers of persons claiming earnings exemptions has increased significantly among PWD claimants – from 4,248 PWD cases claiming earnings exemptions in September 2000 to 9,102 in August 2006. There was a particularly rapid increase beginning in April 2006, which coincides with the increase of the exemption to \$500 per month.”¹⁸ However, Cohen (2008) points out that the increase in the number of PWD claimants can be deceptive, since at the time the income exemption was increased, there

¹⁷ Cohen and others (2008), p.11

¹⁸ Cohen and others (2008), p.15

was also a significant increase in the number of the PWD caseload. In reality, less than 16% of the PWD caseload claimed any earnings.

According to Cohen (2008), the percentage of PWD claiming earnings exemptions increased from 10.9 per cent of the caseload in September 2000 to 15.2 per cent in August 2006. The figures suggest that increasing the exemption amount creates an incentive for people to seek employment. However the 100% clawback still keeps a large number of PWD out of the labour force. Cohen (2008) argues that combining the flat rate with gradual earning exemptions would be preferable. This would mean reducing the 100% clawback to 50% from each dollar earned above \$500. This measure alone would increase the incentives for PWD and PPMB to participate in the labour force.

It seems clear that allowing PWD to increase their earning exemptions increases labour force participation rates and creates a positive incentive for PWD to seek employment. On the other hand the 100% clawback still creates a disincentive to employment and participation in the labour force.

All of the social enterprises surveyed in BC have also reported that engaging PWD or PPMB in employment has “resulted in improved self-esteem, increased independence and broader social networks for their workforce.”¹⁹ A number of social enterprises also reported “a decrease in use of health care and mental health services by their participant-employees, shorter and fewer hospitalizations, the near elimination of criminal activity, and stabilized housing as well.”²⁰

The worries of persons with disabilities with respect to their loss of benefits also stem from the fact that although in BC the status of PWD is designated as a permanent one, the legislation allows the minister to overturn this designation. According to Cohen (2008), the policy also allows that each recipient of PWD benefits can have his/her status of disability reviewed within five years. In fact, an individual’s disability status in BC is not a permanent one. The policy in BC is also not clear on how long PWD can be off disability benefits or income assistance and remain eligible for a quick reinstatement.

“Basic needs such as health care, prescription drug costs, eye care, dental care and transportation all have significant additional costs for many persons with disabilities. The prospect of losing those benefits can act as a strong disincentive to seeking employment income.”²¹

Further, the loss of disability benefits could lead to a total or partial loss of income during months when PWD or PPMB may not be able to work due to poor health conditions, seasonal slow-downs or unexpected lay-offs.

This policy creates another barrier if PWD seek employment. If PWD decide to come off income assistance, they are liable to a lengthy re-application procedure to determine whether they are financially eligible for the benefits. The process requires completion of a complicated 23-page form and a “doctor must confirm the applicant has a severe impairment that is likely to last for at least two years. In addition, an assessment must be performed by a doctor or other health professional to establish whether the person is significantly restricted in performing daily living activities so they need significant help.”²²

¹⁹ Cohen and others (2008) p. 40

²⁰ Ibid

²¹ Cohen and others (2008), p.19

²² Cohen and others (2008) p. 11

Moreover, establishing eligibility for PWD benefits is very difficult. Eligibility for disability assistance is income and asset tested. However, because the income and assets tests are slightly higher than those set for basic welfare, a person may be told they are not eligible for welfare, but they are eligible to apply for PWD; this means that they do not receive benefits until the PWD designation is granted.

Given the current state of legislation, policies and regulations in the province, if a PWD becomes employed, they risk losing their benefits or being downgraded or disqualified to be eligible for the benefits on the review of their status.

Unlike BC, Ontario and Alberta provide examples of policies that encourage people with disabilities to seek employment. For example, Ontario's new policies eliminate time limits for reinstatement, while Alberta's rapid reinstatement for 2 years could help address the disincentives that remain in BC.

Current policies slightly favour PWD rather than PPMB when it comes to maintaining the extended health benefits once a person comes off income assistance or disability benefits. BC policy allows PWD, but not PPMB, to remain in the labour force and still keep their medical coverage once there are employed and off PWD benefits.

However, according to research conducted among seven social enterprises in BC the reality is different from the policy. "According to the ministry, PWD, but not PPMB claimants *are* eligible for most of their enhanced medical and dental benefits including: a full waiver of their Medical Services Plan monthly premium; 100 per cent PharmaCare coverage (prescription costs paid); medical equipment and supplies; and, basic dental and orthodontic services.

None of the seven social enterprises interviewed over the course of the present research were aware of this policy. When our researcher discussed the ministry's policy with them, some expressed concerns that PWD claimants would still be at risk of losing retained benefits if their PWD status was terminated upon a scheduled or unscheduled review. They also expressed concern that retained benefits would be time limited."²³

The risk of losing the extended medical benefits not only creates disincentives to staying employed, but also to transition into full-time work and get off of disability benefits.

Community Volunteer Program

The Community Volunteer Program (CVP) is another policy meant to encourage PWD and PPMB to gain work experience and build employable skills. This program provides the PWD and PPMB with an extra \$100 per month to cover their costs associated with the volunteering activities.

Between 2001 and 2006, the percentage of PWD and PPMB who accessed the program decreased. As a result, the government decided to increase the ease of access to the program for an additional 2,500 PWD and PPMB. This action resulted in doubling of PWD and PPMB in the program.

This sharp increase illustrates the large demand that exists for this program. Other programs to enhance PWD and PPMB chances for employment are funded by the provincial government, however "there are few supportive employment programs funded by the federal government."²⁴

²³ Cohen and others (2008), p.36

²⁴ Cohen and others (2008) p. 23

Supportive Employment Programs

Following is a brief overview of the BC Supportive Employment Programs (SEP) followed by a comparison with the provincial ministry's Employment Program for People with Disabilities (EPPD).

SEP usually offer people with disabilities a supportive environment at minimum wage or higher. The emphasis is on each participant's interests and preferences and relatively rapid placement into employment with ongoing employment support. This model of employment programming has been relatively successful in bringing PWD into the mainstream workforce.

A review of SEP in four Canadian provinces in 2002 found that PWD entering mainstream jobs have seen their incomes increase, and they also expressed a high level of satisfaction with their work, workplace and colleagues. The support staff working in these programs also highlighted how powerfully the employment has affected the feeling of social exclusion and low self-esteem among participants.

Six of the BC SEP are community-based and operating within larger agencies. Out of these agencies, 5 were non-for-profit and one was a for-profit business. Two of these programs were college-based special education programs. Three of the SEP focus on people under the age of 25 with developmental disabilities and the other three of the eight programs focus mainly on participants aged 20 to 30 years old. One program helps people who are over 45 and one program is designed for people of all ages (Coastal Mental Health Foundation).

The success of SEP can be evaluated according to the rates of employment placements and job retention of the participants of these programs. As may be seen from the table below, the majority of participants in the employment programs worked part-time. The reason for the preference of part-time employment ranged from limitations due to disability to the provincial \$500 flat earning exemption and 100 per cent clawback.

Organization	% Employed full-time	% Employed part-time	% Employed	% Employed after 6 months	% Employed after 12 months
Coast Mental Health Foundation	–	–	40%	–	–
Canadian Mental Health Association ^{b,c}	–	–	54%	–	–
Stepping Stone Community Service Society ^d	3%	33%	36% ^e	27%	18%
Garth Homer Society	0%	60%	60%	–	–
POLARIS Employment Services Society ^b	10%	36%	47%	27%	20%
Provincial Networking Group Incorporated	15%	56%	72%	72%	67%
Douglas College	59%	22%	81%	66%	66%
Vancouver Community College	0%	80%	80%	70%	70%
Notes ^a Unless otherwise indicated, program participant totals are based on tracking information provided by the agencies for 2005–2006. ^b The statistics for POLARIS and CMHA include both new participants in 2005–2006 and participants carried over from the previous year. ^c April 2006 to March 2007 totals provided for CMHA. ^d 2004 to 2005 annual totals provided for SSCSS. ^e SSCSS's competitive employment outcomes may be indicative of the older populations the society works with, i.e. most participants serviced between 2004 and 2005 were over the age of 45.					

The survey of the placement rates of the selected programs shows that programs that focus on people with psychiatric disabilities achieved placement rates of 36 to 54 per cent. In comparison, the programs that work with people with developmental disabilities managed to achieve placement rates of 47 to 81 per cent. These results are comparable with a study of placement and retention rates of organization in southwestern Ontario. The Ontario study showed that people with developmental disabilities were the most successful in gaining employment with 64 per cent success rate, compared to only 48 per cent success rate for people with psychiatric disabilities.

When comparing the success of the above-mentioned programs with BC's Employment Program for People with Disabilities (EPPD), the ministry's program achieved only 12.5 per cent placement rates for people who participated in the program between 2003 and 2007. According to the ministry 1,542 people, out of a group of 12,285 participants, managed to obtain employment.

The Ministry of Employment and Income Assistance (MEIA) also funds the community and college-based employment for PWD and PPBM under the Labour Market Agreement for Persons with Disabilities (LMAPWD).

In 2003 the MEIA introduced a new, more business-oriented funding model. Under this model the government awards contracts through a competitive bidding process, and consequently the funding is based on "pay-for-performance". Contractors are paid a set fee to deliver predetermined outcomes. Under this new model the drop out rates of PWD reached 59 to 78 per cent compared with zero to 23 per cent drop out rates of PWD in community and college-based employment programs.

The agencies that were interviewed identified a set of issues that limit the functioning of the government's "pay-for-performance" programs. The agencies identified the following issues:

- A complex system of automated voice messages when government provided numbers are called
- Long assessment periods for PWD and long waitlists
- Because agencies need to meet certain quota of people that are placed into employment, the focus is on less affected participants, while SEP organizations offer employment and training opportunities to a wide range of PWD.
- The MEIA programs do not offer ongoing employment support, which is critical in making sure that PWD retain employment in the long run.

Employment Policies for Persons with Disabilities and Persons with Persistent and Multiple Barriers to Employment

Given what has been said about the negative effects of current BC policy with respect to encouraging the transition to employment for persons with disabilities and indeed, others on social assistance, what are some government policies that have been effective in addressing the issue of disincentives?

A recent policy review in Ontario evaluated the key barriers to employment for PWD. The new policy includes, among other things, a \$100 monthly transport allowance, an employment start-up benefit, changes to earning exemption rules, an easier process to re-qualify, elimination of the time limit for reinstatement and continued eligibility for medical and dental benefits while in employment.

Ontario has seriously addressed the issue of non-employment costs to PWD when transitioning into employment. The province provides a start-up benefit of up to \$ 500 in any 12-month period to reimburse expenses for work clothing, tools or equipment, and grooming costs. Also, for any employment related activities, Ontario provides a \$100 per month transportation benefit.

The province of Manitoba provides employment supports during the first year of employment for work clothing, bus passes and childcare.

Across Canada, Alberta has the most stringent eligibility definitions for disability benefits, but also has the most generous benefits. For example the asset limit per person in Alberta was \$100,000, compared to \$3,000 per individual in BC.

As a result, PWD in BC are expected to expend all their assets prior to becoming eligible for disability benefits. Setting the levels of personal assets at such low levels impoverishes applicants and makes it increasingly difficult for many PWD to get through emergencies or unexpected changes in circumstance when occasional expenses are higher than their disability benefit.

In Alberta a single adult can earn a flat rate monthly exemption of \$400 and then retain 50 per cent above that amount up to a total exemption of \$700 (total earnings of \$1,100 per month).

Australia provides an employment payment of up to \$312 if new employment is expected to last more than 4 weeks. Further, wage subsidies are also available to encourage hiring and transitioning of PWD into the workforce. The situation in the US is similar, with respect to incentives for individuals and employers.

Australian government policy provides additional financial support to offset the cost of drugs.

Australia also has a unique option of accumulation of “work credits” when the income earned in two weeks is below \$48. This “work credit” system allows accumulation for up to 1,000 credits. The system allows PWD not to be penalized when their income is above the threshold for a short period of time. Over the time, the credits are used to even out the flow of earnings in the future. The system is especially beneficial for people whose income periodically fluctuates with their employment status.

In Sweden, everyone under the age of 20 has universal medical coverage, so these benefits also apply for PWD. Sweden also allows people to apply for trial periods of work, up to one year, while receiving benefits and employment income. PWD can have their benefits made dormant for up to 24 months, however for PWD under the age of 30 the benefits are immediately re-accessible up to age 30.

With respect to earning exemptions, government policy in Sweden allows PWDs to work up to one year without any penalty or loss of benefits. Lastly, a means tested system is in place that allows people PWD to apply for benefits while they are employed.

A Way Forward – the flexibility of social enterprise

Social co-ops and social enterprises have been shown to be effective in accommodating the special work requirements of PWD or PPBM in several ways:

“Shorter work days, more breaks than required by the labour standards act, exclusive part-time scheduling in recognition of participant-employees’ earnings exemption thresholds, casual on-call scheduling, a lighter mix of physically demanding jobs, adapting tasks to individual ability (especially in terms of dexterity and memory), choosing specific work contracts to complement employee capacity, and/or facilitating the return of participant-employees after a pause of unemployment due to poor health.”²⁵

²⁵ Cohen and others (2008) p. 37

Yards R Us is different from other social enterprises in the province because it is a workers' co-operative - the participant-employees at this social enterprise have the opportunity to collectively "determine their own wages on a biweekly basis, and vote annually to determine their manager's salary."²⁶

Among other social enterprises "choosing the type and hours of work represents the most common decision-making practiced by participant-employees, although participant-employees are also encouraged to participate in business planning and development, or annual meetings."²⁷

The Right Stuff organizes quarterly meetings with all of the employees to review and inform them about business revenues and output, while trying to collect input from the employees in attempt to explore ways and means to increase enterprise efficiencies.

Barriers to Sustainability of Social Enterprises

Social enterprises in BC are utilizing the permanent employment model. Formerly, these enterprises were concerned with creating job opportunities utilizing a transitional employment model that prepares PWD and PPBM for employment in the labour market. They have since discovered that their participant-employees do not want leave their current places of employment for other work.

Further, people engaged in running these social enterprises have realized that low rates of worker termination and resignation reflect superior workplace accommodations and the importance of on-the-job support, which are pre-requisites for a successful employment strategy of the target populations.

The social enterprises have been capable of developing a competitive advantage in training and workforce development and integration. This is reflected in high job retention and low turnover, which translates into lower job training and orientation costs for the employer.

As indicated above, the social enterprises in BC have managed to generate growing revenues since the start of their operations. The **Right Stuff** is entirely self sufficient and some of the enterprises are starting to break even while being able to cover their operating expenses through their revenues.

What most distinguishes social enterprises from mainstream competitors is the cost associated with employing, training, supporting and accommodating people with psychiatric or developmental disabilities. Not only do social enterprises face higher support costs when compared with private firms, they must also recoup these costs by attempting to increase revenues.

Social enterprises often see their profitability drop until the disparity between costs and revenues stabilizes over a period of time. At the same time, the research by Cohen (2008) highlights that apart from higher costs associated with employing a special needs population, decreased profitability is also caused by a lack of business expertise and lack of capital that "presents the greatest barrier to self-sufficiency and long-term sustainability."²⁸

As Cohen (2008) points out, "most of these social enterprises were founded and developed by people with no business experience or training, and with little to no capital to invest."²⁹ In a majority of the cases,

²⁶ Cohen and others (2008) p. 42

²⁷ Cohen and others (2008) p. 42

²⁸ Ibid

²⁹ Ibid

agencies have been able to provide some seed funding for start-up capital, but lacked the expertise or resources to directly assist the social enterprises with building organizational and entrepreneurial capacity.

Conclusion

The review of social policy programs for labour integration of PWD and PPBM in BC has highlighted major obstacles for the use of social co-ops and social enterprise models for serving these populations. The barriers range from policy disincentives in the transition from a state of income dependency to employment, and the use of inappropriate models for recruitment, on-the-job-training, and work organization that limits the utility of these programs for labour integration of PWD and PPBM.

In addition, the application of narrow commercial management techniques such as “quantifiable” job placement measures without recognition of the special employment measures required by service users, including follow up support, suggests a fundamental lack of understanding of the social dimension in the training and employment of these individuals. This is an area where social co-ops and social enterprises are most effective and the absence of a concerted strategy to learn from, and expand, the successes of this approach are a major policy failing in this province.

Moreover, the general attitudes displayed in the policies currently in place, especially in regard to the application of commercial measures and private sector models to the delivery of social and relational goods, mirror in many respects the narrow utilitarian philosophy that has been adopted by the province with respect to the design and delivery of health services.

The research undertaken for this paper suggests a list of policy barriers and the remedies that can help make public policy in BC more effective and supportive of PWD and PPBM in the pursuit of employment opportunities and integration into the workforce.

Barriers to employment for PWD and PPBM

- a) Access to benefits is limited to PWD only while undertaking employment, however re-assessment of the eligibility can easily lead to a loss of the extended medical benefits and disability benefits.
- b) Reinstatement is slow and complex and requires a 23-page application form and other documents. The process of reinstatement can also jeopardize one’s economic security.
- c) Eligibility for disability assistance is income and asset tested and PWD do not receive benefits until the authorities grant the PWD status. In BC the PWD status is only temporary.
- d) Low personal asset limits creates disincentives to work since the income might not be sufficient to cover unexpected the costs such as medical treatment while out of labour force.
- e) Earning exemptions limit of \$500 per month limits the hours available for work and severely limits PWD participation in employment even though some PWD are physically and mentally capable of working more.
- f) 100% clawback reduces any income earned above the income exception dollar-for-dollar and creates a huge disincentive for PWD to fully integrate into a full time or part time employment, as any dollar earned above \$500 is a dollar lost.

- g) Given that the majority of people receiving disability benefits in BC do not receive additional income from the labour market, the following policies were identified to ease the transition into to labour market for PWD and PPBM.

Enabling Policies and Remedies

The following policies and practices would serve to address the disincentives to training and employment that currently prevent PWD and PPBM from participating in the labour force.

- a) Ensuring that the medical and dental benefits are fully available to people who are transitioning into employment. This policy is currently in place but has not been well communicated to those who work with the target population.
- b) Ensuring unlimited reinstatement and rapid re-qualification for income benefits, including earning exemptions.
- c) Providing monthly transportation allowance for people who access any employment or volunteer opportunities.
- d) Increasing the earning exemption and reducing the 100% clawback on income to 50%.
- e) Raising the personal asset limit to \$100,000 as in Alberta.
- f) Developing a “working credit” system to help even out the flow of earnings exemptions when working.
- g) Developing an employment start up benefit of up to \$500 for any employment-related activity.
- h) Improving government funding criteria and inclusion of input from the key stakeholders in development of the criteria.

In addition to the above measures targeting disincentives to employment, the following measures would greatly improve the environment for the development of social co-operatives and other social enterprises as models for the delivery of services to vulnerable populations for employment training and placement and for the delivery of social care.

- a) The benefits of the social co-op model should be clearly communicated and presented to the provincial government and the regional health authorities by national and provincial co-op bodies;
- b) Marketing strategies focusing on the benefits of co-op models for social care should be carried out by national and regional co-op associations in collaboration with existing social co-ops, social enterprises and other supportive stakeholders;
- c) Democratic user control should be recognized as a desirable element of effective social care and co-operative social care models should be promoted as a means of achieving this;
- d) Legislation should be developed that formally recognizes the use of non profit and user controlled social co-ops and social enterprises as delivery agents for labour and social integration programs and the provision of social care to marginalized and special needs groups;
- e) There should be formal recognition of marginalized and special needs groups that are eligible to be served by social co-ops under the legislation and tax provisions supporting social co-ops; these would include, but not be restricted to, people with disabilities and barriers to employment, seniors, youth at risk, recovering addicts, and the homeless;

- f) Government procurement practices and requests for proposals should include a social tendering provision that reserves a portion of government social care contracts to community initiatives, social co-operatives and other non-profits.
- g) Large government contracts should be “unbundled” to enable social co-ops and social enterprises to establish a proven record, build local expertise, and develop legitimacy in provision of social care services.
- h) Start up funding up to 50,000 should be established as part of a program for the development of social co-ops and social enterprises that serve marginalized populations and that incorporate a user control model and a multi stakeholder structure;
- i) Service subsidies should be established to cover the gap between the cost of social care in these organizations and the ability of users to pay;
- j) The Co-operatives Act should be revised to designate Community Service Co-ops as a model for social co-ops;
- k) The Co-operatives Act should be revised to allow community service co-ops to issue social investment shares for the purpose of capitalizing social care services;
- l) Tax policy should be revised to allow exemption of mandatory employer costs for social co-ops that employ over 25% of staff from a marginalized group.

In summary, it is obvious that many of the recommendations proposed above reflect the kinds of policy changes that were outlined in the section dealing with the use of co-operative models for the delivery of health care. Both sets of policy recommendations advocate for the promotion of a community based approach in the delivery of public services, and in particular the adoption of user control rights as a key element in the redesign of health and social care.

Such an approach, slowly being adopted in Quebec and showing such promise in countries like Italy, require a wholly different philosophy of public goods and services than that which has been gaining ground in Canada for the past two decades.

To be sure, the kinds of policy changes proposed in this paper are being brought before governments at all levels by groups active in the social economy. And in BC, a broad coalition of organizations have joined forces from a cross section of social service groups, social enterprises, CED organizations, foundations, and co-operative organizations to push for the kinds of changes that would increase the power of health and social co-ops and other types social enterprise to contribute their particular strengths to the delivery of health and social services in the province.

It remains to be seen whether, and to what extent, provincial policy makers and government agencies will be prepared to broaden current practice to make room for service models that operate on a different pattern of assumptions from those that have become embedded in the culture of the province’s public service.

One thing however, seems certain. Practitioners and the consumers who benefit from the kinds of models outlined in this paper must be prepared to press their case for alternative models through a combination of rigorous documentation, effective marketing and education, and strategic political pressure. Otherwise, the kinds of changes in government policy and operations that are central to the development of innovative, consumer based models of health and social care will not create the space for viable alternatives to the large scale, commercial oriented service models currently being pursued both by government and the private sector.

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Appendix 1 Alternative Financing of Health Care and Social Co-ops

The following examples offer a variety of financing strategies currently in use for the capitalization of co-operative and social enterprises. Some have been used to a small degree in BC. Others, such as the Community Capital program now in use in the UK, require a new level of organization and investment not currently available in the province.

Community Capital – UK

In the United Kingdom, the co-op movement has been supported since 1973 by the Co-operative and Community Finance (ICOF), which manages a revolving loan fund in which money is loaned, repaid and then lent again. The ICOF manages several funds that lend to co-operatives, community businesses and social enterprises.

Community Capital is a UK investment society that was founded in 1994 by ICOF to finance the purchase of co-op member shares by individuals and organizations. The shares are withdrawable and subject to certain conditions. These investments are primarily social in purpose and not intended for personal gain or profit.

Community Capital invests in viable social businesses with interest paid on the investment if the enterprise generates a surplus. The minimum investment in the capital fund is £250 and the maximum is set at £20,000. Capital investments are then made available as loans to co-operatives or social enterprises with loans ranging from £5,000 to £50,000.

What makes this system successful is that every £1 that is repaid is immediately available for lending to another business. Nearly £1,750,000 has been loaned since the fund was created. From the £1 million raised from the initial share issues, the ICO Fund has lent over £3.3 million to 150 enterprises, which in turn generated 1,500 new jobs within the co-op sector. In 2007 ICOF has placed a target of 70% of the investments to be placed with co-operatives.

Coopfond – Italy

Similar to the Community Capital model, Coopfond is a capital investment fund operated by Lega Cooperativa e Mutue in Italy. Otherwise known as the 3% fund, this equity fund is capitalized through a 3% levy on co-operative before tax surpluses. A separate co-op investment fund has been set up for each of Italy's three co-op federations, along with one fund that is managed by the Ministry of Labour for non-affiliated co-ops.

Coopfond invests exclusively in co-operatives associated with the Lega federation and the equity is invested in a co-op in the form of a purchase of the co-op's shares by the fund. Once the co-op is generating a sufficient surplus, the Coopfond shares are bought back by the co-op.

A key feature of Coopfond is its close working relationship with the members of Legacoop for specialized investment analysis and technical assistance for loans to co-ops operating in specialized sectors. This availability of technical support, and a stringent screening and application process for investments has resulted in a very positive loan to loss ratio for the fund.

Community Bonds in British Columbia

Community bonds are another way to raise capital in support of development for co-ops or social enterprises.

The Municipal Finance Authority (MFA) in BC acts as the central borrowing agency for financing of the capital requirements of regional districts and their member municipalities and hospitals. The municipalities and regional districts own the MFA with each municipality owning one share. There is no provincial ownership involved.

The MFA provides both long-term and short term financing, investment management, leasing, and other financial services to municipalities in BC. Financial services are available for pooled investments, capital financing, interim financing and community bonds.

Community bonds benefit communities not only by providing access to capital for community initiatives, but the interest paid to bond holders is spent in the local community. Community bonds also create a sense of community ownership in invested projects while allowing communities to save on interest since the bond rate is below rates demanded by conventional bond markets.

Community Development Loan Funds (CDLF)

CDLFs are locally based and capitalized non-profit sources of credit, usually for affordable housing projects, or locally based businesses that employ local residents. CDLFs offer credit but some have diversified in order to offer equity investments and even financial management services. CDLFs tend to be regionally focused and serve the needs of local communities.

At the core of a CDLF operation is re-lending capital that has provided by mostly private sources to meet the capital needs of a local community. The borrowers usually pay two to three percent higher interest than what the loan fund pays the lenders. The spread covers the administrative and transaction costs. One benefit of CDLFs is that they can operate without the restrictions that apply to conventional financial institutions. Also, because community development is the primary mandate of these funds, CDLFs do not need to earn the profit rates for shareholders that would apply in conventional investment funds.

Community Equity Investment Funds (CEIF)

Like CDLFs, CEIFs can be organized in a non-for-profit structure, yet they can provide a profit for investors. These funds, also known as Community Economic Development Investment Funds (CEDIF), can also operate as co-operatives or conventional corporations. Being incorporated as a non-for-profit or a co-op, protects the CEDIF from outside investors and ensures the primary focus of the fund local development.

Engaging volunteers with business and investment background to serve on the board and to provide technical assistance minimize operational expenses in CEIFs.

Often, partnerships are developed with private firms and people that specialize in a particular field of investment, much in the same way as Coopfund works with co-operatives to undertake business analysis, perform due diligence, provide industry expertise, etc. The use of this kind of networked expertise provides firms with the knowledge they require to adapt quickly to changes in the market or their industry and to promote new ventures.