

Social Policy as a Determinant of Health: The Contribution of the Social Economy

This summary is primarily based on a paper and presentation by Yves Vaillancourt, Director of the Laboratoire de recherche sur les politiques et les pratiques sociales at the Université du Québec in Montréal, and a response by Pat Armstrong, Canadian Health Services Research Foundation/Canadian Institutes of Health Research Chair in Health Services and Nursing Research. The presentations were prepared for The Social Determinants of Health Across the Life-Span Conference, held in Toronto in November 2002.

The opinions expressed in this publication are those of the authors and do not necessarily reflect the views of Health Canada.

In Quebec, the term “social economy” is widely used and refers to a vast array of groups, mostly non-profit organizations including advocacy groups, voluntary organizations and other community-based organizations, including cooperatives. The term is not widely used in English Canada but is most close to the term “voluntary and community sector” (which includes organizations dealing with both voluntary and paid work) (Vaillancourt, Aubrey, Tremblay and Kearney, 2002). At the Economic and Employment Summit in Quebec in 1996, social economy organizations were defined as follows (Chantier de l'économie sociale, 1996):

Social economy organizations produce goods and services with a clear social mission and have these characteristics and objectives:

- The mission is services to members and community and not profit-oriented.
- Management is independent of government.
- Workers and/or users use a democratic process for decision-making.
- People have priority over capital.

Participation, empowerment, individual and collective responsibility are key values.

Current Situation

Organizations in the social economy play a major role in many spheres of economic and social life, in particular in the areas of health and social services, labour market integration and other social policy areas that affect health. The importance of the non-profit sector varies substantially from one country to another, but can exceed 10% of total employment in countries such as Holland, Ireland and Belgium (Defourny et al., 1999).

In Quebec, the social economy represents more than 120,000 jobs in 8,000 organizations of which 3,000 are cooperatives. The social economy generates about 7% of the province's income (Chantier de l'économie sociale, 2001). The Department of Health and Social Services alone finances more than 2,500 organizations.

Community-based organizations are particularly active in four areas related to the social determinants of health:

- **Homecare services:** Not-for-profit organizations now employ 5,500 workers in 103 community-based organizations that offer services to 62,400 clients across the province (Ministère de l'Industrie et du Commerce, 2002).
- **Day care services:** The 1997 Quebec Family policy announced that day care services would become universally available for a minimal fee of five dollars per day per child. This innovative program stimulated an increase of day care spaces from 78,000 in 1998 to 145,000 in 2002. Early childhood day care centres employ 22,000 people. This makes it the third most important employer in Québec, outside of the public sector (Vaillancourt, Aubrey, Jetté and Tremblay, 2002).
- **Social housing:** Since the 1960s, 49,000 cooperative and non-profit housing units have been created in Quebec (Vaillancourt and Ducharme, 2001).
- **Job creation and integration:** Many community-based organizations are actively creating jobs and providing

- employment services for victims of social exclusion.

Women account for over 80% of workers providing care in both the public sector and the social economy (Armstrong, 2002). They also provide most of the unpaid, domestic care for children and family members who are ill or in need of assistance.

Factors that Affect the Issue

Mainstream trends in health reform are caught up in a bipolar state/market model that tends to exclude the social economy and take advantage of the unpaid caring work provided by families. The social economic sector is not recognized as a significant capacity builder and the important work of community organizations is still too timidly acknowledged (Vaillancourt, Aubrey, Tremblay and Kearney, 2002). As a consequence, many people in the public health sector in Quebec do not understand that leaders in the social economy are key allies in advocating action on the non-medical determinants of health.

This lack of recognition also leads to insufficient funding from governments, even though their services are meeting a need that the private sector cannot or does not want to adequately address. As a result, many voluntary organizations must deal with difficulties related to poor financing, such as manpower shortages, low wages and high turnover (Ministère de l'Industrie et du Commerce, 2002; Vaillancourt and Jetté, 1999a; 1999b; 2001). If governments believe that community-based organizations can ensure quality services in which users and producers have a say, more resources must be allocated for them to do so.

Until the end of the 1980s, caring work in the public sector with decent wages and high rates of unionization meant job security and relatively good jobs for many women (Armstrong and Cornish, 1997). Reforms that move these jobs to the social economy or eliminate them could lead to lower paid jobs and/or an increased burden on women in families who have had to voluntarily fill in the gaps in caring for children, spouses and older people who are ill or disabled. The Quebec Women' Federation and others have argued that shifting good jobs in the public sector to poor jobs in the social economy would increase inequality for women (Boivin and

Fortier, 1999). Thus, a consensus has been developed in Quebec that sees the social economy sector and the public sector as complimentary, and that there should be no job substitution.

Increasingly, since people are sent home from hospital "quicker and sicker", unpaid women caregivers are asked to do highly skilled tasks, such as inserting catheters and applying oxygen masks. Without adequate training and support, women who are pushed to do these tasks may provide poor care and end up in poor health themselves. In Québec, such professional services remain the responsibility of the public sector.

Because women give birth and live longer than men they are also the majority of patients requiring care. Their relative poverty means that women have fewer financial resources and are more dependent on social services than men (especially older women). Aboriginal women and women from immigrant, refugee and visible minority communities often face racism and language and cultural barriers as well.

Effects of the Social Economy on Health

The social economy can contribute in many ways to the health and well-being of individuals, families and communities.

- The values at the heart of the social economy and the democratic rules that govern them facilitate the empowerment of users and workers within organizations that provide direct services. The Independent Living Movement is an example of such empowerment where users, instead of being considered passive beneficiaries, become active participants in the decisions that concern them. This is directly opposite to traditional welfare policy reforms that consider the user solely as the receiver of social policy. The empowerment of workers also has positive impacts on the quality of life in the workplace, and on employees' health and well-being.
- The social economy has the capacity to mobilize civil society to instigate social policy reform, thus contributing to "citizen empowerment" or "active citizenship". The development of early childhood day care services in Québec since the 1970s and

the new family policy put in place in 1997 are examples of this.

- The social economy can exert a positive influence on the values and practices of public and for-profit organizations. These include more democratic forms of governance in the public sector, increased openness to the empowerment of users and workers, and increased participation by local communities and their networks.

Over the last 30 years, a large number of social economy have developed innovative practices in response to increasing health and social problems (Vaillancourt, 2002; Vaillancourt and Dumais, 2002). Examples in Quebec include:

- Accès-Cible (Santé Mentale et Travail) is an organization that offers job integration activities to individuals with mental health problems. Over the last 14 years, Accès-Cible welcomed over 800 persons in group workshops, office skill learning, employment services and professional training practice. Some 60% of participants found a job that helped them take better control on their life and health (Dumais, 2001).
- It is well known that care and stimulation in early childhood has positive effects on development and future health. The non-profit orientation of day care services and the democratic participation of parents and staff on the boards of day care centres are distinguishing feature of Quebec's program. This empowering environment is a positive determinant of well-being, not only for children and parents but also for the entire community.
- Increasingly, social economy enterprises provide domestic services (cleaning and maintenance, meal preparation, etc.) to an aging population or people with temporary or permanent disabilities. Partnership relations are established with local public sector agencies (CLSCs), which ensure that appropriate referrals are made.
- Social housing with community support is a new practice that allows vulnerable people to have a decent home, to make their own decisions and assume normal tenant responsibilities (Vaillancourt and Ducharme, 2001; Jetté, Thériault, Mathieu and Vaillancourt, 1998; Thériault, Jetté, Mathieu and Vaillancourt, 2001). For example, social economy organizations deliver community

support services (onsite janitor-supervisors and visits by service workers) for people who have unstable housing connected to substance abuse, mental health problems and HIV/AIDS.

While many caregivers (who are almost all women) are rewarded by providing care, when they are conscripted into voluntary care roles their emotional and physical health is likely to be negatively affected. Some women need to interrupt their careers in order to provide care for family members, thus losing their financial base and status for the future. The development of social economy services that are not provided by the public sector (such as house cleaning) can provide much needed help for these women.

Although the social economy, like the private for-profit sector, provides employment of varying quality, women who work in low paying caring roles within the social economy usually have few benefits. In some parts of Canada, women who are welfare recipients may be conscripted into these jobs, regardless of their interest or experience. All of these situations can lead to poorer health among women caregivers in the short- and long-term.

Implications for Policy, Practice and Research

It has been demonstrated in Quebec (and elsewhere) that providing support for the social economy can effectively address current and urgent health and social policy issues, including:

- affordable, universal day care
- social housing with community support as a viable alternative to institutionalization
- job integration programs for vulnerable and socially excluded citizens
- the need to help an aging population remain independent in their own homes and communities.

The move toward more community care through social economy organizations can decrease the burden for natural helpers, who in the vast majority of cases are women. However, policy-makers must ensure that

this support is realized and accessible (and not just “promised”), and that it is not provided at the expense of secure public sector jobs for women.

Even when the social economy makes breakthroughs at the policy level, the gains remain precarious unless health departments and other areas of government enact policies that:

- provide sustainable and adequate funding which enables organizations to strengthen and develop their activities, and maintain their independence and empowering ways of working
- recognize the contribution of the social economy
- do not force not-for-profit organizations to adopt private sector management and assessment models in order to compete with private enterprises
- support local control and the participation of representatives from the social sector in decision-making and consultation processes
- ensure social economy organizations an even greater role as partners in the social policy area.
- specifically take gender and culture into account
- do not shift all of the less profitable and more burdensome work to the social economy sector while allowing for the expansion of profitable private services
- support the integration of acute health care with care in the community, as opposed to separating the two in favour of the medical model over the social determinants of health.

Leaders in health can look to expanding alliances with organizations in the social economy in their efforts to improve living conditions that affect health and well-being.

When it comes to caring work, gender inequities within households and in the labour market must be recognized and addressed. A social economy approach devoted to the democratic organization of work should positively promote equity by ensuring that care work is both more equally rewarding and equally distributed. Given what we know about the determinants of

health, such equity would necessarily contribute to improved health for women.

References

- Armstrong P. (2002). *The Contribution of the Social Economy: A Response*. A presentation given at The Social Determinants of Health across the Life-Span Conference held in Toronto in November 2002.
- Armstrong P and Cornish M. (1997). Restructuring Pay Equity for a Restructured Workforce: Canadian Perspectives. *Gender, Work and Organization* 4:2 (April 1997):67-86.
- Boivin L and Fournier M. (1998). *L'Économie Sociale: l'Avenir d'une Illusion*. Montréal: Fides.
- Chantier de l'économie sociale (1996). *Osons la solidarité*. Rapport du groupe de travail sur l'économie sociale, Sommet sur l'économie et l'emploi, Québec.
- Chantier de l'économie sociale (2001). *De nouveau nous osons*. Document de positionnement stratégique, Montreal.
- Defourny J., Develtere P. and Fonteneau B. (Eds) (1999). *L'Économie sociale au Nord et au Sud*. Brussels: De Boeck Université.
- Dumais L. (2001). *Accès-cible (SMT) : Monographie d'un organisme d'aide à l'insertion pour les personnes ayant des problèmes de santé mentale*. Montreal : UQAM, Cahiers du LAREPPS 01-06.
- Jetté C., Thériault L., Mathieu R. and Vaillancourt Y. (1998). *Évaluation du logement social avec support communautaire à la Fédération des OSBL d'habitation de Montréal (FOHM)*, Montréal: UQAM, LAREPPS.
- Ministère de l'Industrie et du Commerce (2002). *Portrait des entreprises en aide domestique*. Québec: gouvernement du Québec, 67 p.
- Thériault L. Jetté C., Mathieu R. and Vaillancourt Y. (2001). *Social Housing with Community Support : A Study of the FOHM Experience*. Ottawa: Caledon Institute of Social Policy, 33 p.
- Vaillancourt Y. (2002). *Le modèle québécois de politiques sociales et ses interfaces avec l'union sociale canadienne*. Montreal: Institut de recherche en politiques publiques (IRPP) (English Version coming in 2003).
- Vaillancourt Y., Aubry F., Tremblay L and Kearney M. (2002). *Social Policy as a Determinant of Health and Well-Being : The Contribution of the Social Economy*. A paper prepared for presentation at The Social Determinants of Health across the Life-Span Conference held in Toronto in November 2002.
- Vaillancourt Y., Aubry F., Jetté C. and Tremblay L. (2002). "Regulation Based on Solidarity: A Fragile Emergence in Québec", in Y. Vaillancourt and L. Tremblay (Eds). *Social Economy. Health and Welfare in Four Canadian Provinces*. Montreal/Halifax: LAREPPS/Fernwood, 29-69.
- Vaillancourt Y. and Ducharme MN. (with the collaboration of R. Cohen, C. Roy and C. Jetté) (2001). *Social Housing – A Key Component of Social Policies in Transformation: The Québec Experience*. Ottawa: Caledon Institute of Social Policy.
- Vaillancourt Y. and Dumais L. (2002) " Introduction ", in Vaillancourt Y., Caillouette J. and Dumais L. (Eds). *Les politiques sociales s'adressant aux personnes ayant des incapacités au Québec: Histoire, inventaire et éléments de bilan*. Montreal: LAREPPS/ARUC-ÉS/UQAM, 3-9.
- Vaillancourt Y. and Jetté C. (1997). *Vers un nouveau partage de responsabilité dans les services sociaux et de santé: rôles de l'État, du marché, de l'économie sociale et du secteur informel*. Montreal: UQAM, Cahiers du LAREPPS, 97-05.
- Vaillancourt Y. and Jetté C. (1999a). *Le rôle accru du tiers secteur dans les services à domicile concernant les personnes âgées au Québec*. Montreal: UQAM, Cahiers du LAREPPS 99-03.
- Vaillancourt Y. and Jetté C. (1999b). *L'aide à domicile au Québec: relecture de l'histoire et pistes d'action*. Montreal: UQAM, Cahiers du LAREPPS 99-01.
- Vaillancourt Y. and Jetté C. (2001). " Québec : un rôle croissant des associations dans les services à domicile", in Laville, JL. and M. Nyssens (Eds). *Les services sociaux entre associations, État et marché. L'aide aux personnes âgées*. Paris: La Découverte/Mauss/Crida.