Human Services and the Caring Society

John Restakis

In Canada, and in the industrialized global North generally, social care systems that took a century to build up have been deeply damaged by three decades of government retrenchment and neglect and by the catastrophic effects of free market ideas on public services. These systems constitute the complex fabric of publicly funded safety nets, from universal health care to unemployment insurance and services to the handicapped, that have been needed to offset the market failures in human services that are endemic to a capitalist system. The response of civil society and of the co-op movement in particular, to the deleterious effects of these free market ideas has, in turn, placed a spotlight on the relationship between sustainability, traditionally connected to the carrying capacity of environmental systems, and the functioning of systems for social care.

Transposing the traditional language of sustainability to the operations of social care systems has its challenges. The issues of growth and consumption, for example, have very different implications for these two fields. In the context of an economic model that depends on the depletion of natural resources, unlimited growth and consumption are by definition unsustainable, but this is not the case in the field of social care and the operations of the social economy. Unlike the capital economy, which, in the production and consumption of material goods, depletes the natural and social capital upon which it rests, the social economy, which is concerned with the production and consumption of human services, is characterized by activities that expand and replenish the social capital that sustains it. How, then, do we understand the question of sustainability with respect to human services, and in particular, with respect to social care? This is one question I address in this chapter.
A second question relates to the relative strength of different models for the provision of social care in terms of their potential to transform and strengthen the social economy and social care itself. In this framework, strong social economy approaches entail fundamental structural and institutional change; increased scale; the creation of deeper and more extensive social networks; greater scope for capacity building, both for organizations and individuals; and viable alternatives that challenge existing regulatory systems and power relationships. The approach outlined below is based on the democratization of social care systems and the strengthening of reciprocity and mutuality. It thus embodies an exceedingly strong model of sustainability within the particular context of the social economy and the social and economic principles upon which it rests.

In particular, what I want to explore in this chapter is the question of how the physiology of human services—their organizational and institutional set-up—either helps or hinders the production of human services that embody what I would call caring relationships: that is, human services that are based on actual relationships among persons as opposed to interaction between persons and impersonal systems. It is from this perspective that I interpret the notion of sustainability with respect to human services—that is, models of human service that have the capacity not only to provide social care but to do so in a manner that embodies and promotes care as an exchange of empathetic human relations. This perspective draws on my own interest in the transformative role of democracy in human services and raises fundamental questions concerning human dignity and the interplays of power.

Let me begin with a story.

In the winter of 2008, in the small town of Trail in the BC interior, Annie Albo lay dying with congestive heart failure in the Kootenay Boundary Regional Hospital. She was ninety-one years old. Her husband, Al, aged ninety-six, was also in the hospital—sick and exhausted from the worry and strain of caring for his wife. They had been married for seventy years.

One day, Annie was wheeled into her husband’s room and told to say goodbye. She was being transferred to a nursing home in Grand Forks, roughly a hundred kilometres away. Hospital staff had already strapped Annie to a gurney, so she was not able to embrace her husband in the few moments before they took her away. They said their goodbyes. Annie Albo died alone two days later, on 19 February 2008. Al died thirteen days after that (Ballem 2006).

When the newspapers broke the story, a wave of outrage swept the province. Angry letters to the editor, withering television coverage, and an uproar in the BC
legislature wrung an apology from the minister of Health and a promise to examine how such a heartless decision could be made. Nurses working at the hospital organized a petition calling for a public inquiry. According to Margaret Kempston, a registered nurse who worked at the hospital, the Albos’ treatment was “horrible and disgusting,” but she added that spousal separation “happens all the time.” The final injury came to light when a government official confirmed that Trail’s single palliative bed was in fact available when Annie Albo was separated from her husband and forced out of the hospital despite the frantic objections of her family. During the course of the examination concerning the conditions leading to the decision, senior managers at the Regional Health Authority refused to answer any questions, saying flatly that proper procedures had been followed. In the end, no one was found to be at fault, no accountability was forthcoming, no disciplinary action was taken. Nothing changed.

This heartbreaking story illustrates perfectly the tragic consequences and needless suffering caused by a dysfunctional human services system. Countless stories could be told of other seniors and other families who have endured similar distress and indignity in communities across Canada and the United States—and indeed, in every place where patients are powerless to influence bureaucracies that serve institutional interests rather than the interests of those they are meant to help. The story of Annie and Al Albo touched a raw nerve across the province. And it was not only empathy that prompted the outpouring of anger. It was also the unsettling question that the story raises in the minds of each of us: Could this happen to me?

Stories documenting the neglect and abuse of seniors have been a staple element in Canada’s headlines and news hours for many years. They are depressingly familiar and just as shocking today as they were thirty years ago. What receives less attention is the pervasive anxiety and silent struggle that millions of seniors face daily as they contend with the challenges of aging with few supports at home, in their communities, or from government. These same fears of isolation, maltreatment, and neglect remain a constant presence in the lives of the vulnerable, whether they are people living with disabilities or those who have, for whatever reason, been left stranded at society’s margins. They have reason to worry. Social care systems have been unravelling steadily over the last twenty years. The economic crisis that began in 2008 and the culture of accelerating government cutbacks and austerity have only deepened the worry.

Historically, the rise of social care in the advanced capitalist societies is inseparable from the advent of democracy, which in turn became possible only
with the rise of an organized working class (Thompson [1963] 1980). A prime cause behind the struggle for democracy in the West was to establish a political system capable of distributing to the majority a share of the material security and prosperity that was the privilege of elites. Such a system only comes to be when there is a commensurate distribution of political power. Progressive social policy—the broad distribution of material security through public means—is a factor of democracy. Democracy is essential for the preservation of human services and the protection of the human and social dimension of social care itself.

The character of social care—its content, its manner of operation, and the distribution of its benefits—has remained relatively unchanged since the great wave of social reform after the end of World War II. It was at this time that the universal systems of social security, health insurance, family benefits, and public welfare were established (Ferrera 2005). And while it is true that the nature and extent of these social care systems varied greatly from one country to the next, and especially between northern Europe and North America, they shared essential common features—in particular, the rising importance of government as the provider of social welfare. But almost all the social policy reforms in Europe and North America since then have been centred on matters of redistribution—extending the coverage of social welfare systems to larger segments of the population (Ferrera 2005; Finkel 2006). The actual delivery of these services—the fundamental character of the relation between the state and the citizen—remained relatively unchanged until free market ideas began to influence public policy in the 1980s, beginning in Britain. Until then, publicly funded social programs were delivered almost exclusively by the state through centralized bureaucracies.

To be sure, these vast delivery systems succeeded in distributing benefits to unprecedented numbers of people. The quality of life for the large majority of people improved dramatically—more than in any previous period of history. Centralized bureaucracies were deemed essential for systems in which universal coverage required regulation, standardization of services, and equality of access. Their moral foundation, however, was based on notions of charity—the social responsibility of the state to care for its members. They were profoundly paternalistic systems in which the state provided and the citizen received. The legitimacy of the state rested on this social foundation. The essential character of this disempowering, and ultimately belittling, system was not to be altered until the 1980s, when, ironically, the state monopoly over social care was called into question by the adoption of free market principles into public services by Margaret Thatcher. This shift in the presumptive role of the state by the embrace of the free market
cracked a centuries-old mould that had fixed the citizen as a powerless dependant of the state in matters of social care. That citizens contributed to the cost of these services through their taxes had little effect on the powerlessness that they often experienced when actually using these services—particularly social welfare, which carried with it the additional indignity of social stigma. It was a model whose antecedents extend back to the Poor Laws of England, which stripped the poor and the weak of their autonomy and social identity. And just as the adoption of utilitarian, free market ideas dissolved the relations between the commercial economy and society at the dawn of the industrial age, so too has the adoption of these same ideas threatened to destroy the social content of care in the public economy (Restakis 2010, chap. 1).

**Multicultural Health Brokers**

*Juanita Marois*

Multicultural Health Brokers (MCHB) is an Edmonton-based workers’ co-operative that seeks to provide health education and improve access to health care services among the city’s immigrant and refugee communities. The co-op has grown from its original twelve members in 1994 to fifty-four health brokers today, who together represent more than twenty linguistically diverse cultural communities. Located in the inner-city community of McCauley but active all across the municipality, the co-op serves over two thousand families (approximately ten thousand individuals). “We are guided by international cooperative principles of social justice, community accountability and democratic governance,” states executive director Yvonne Chiu, a founding member. “Our work now covers the whole life stage of pre-natal to infants, children/youth, adults, and the golden years—we have a program that supports isolated immigrant/refugee seniors” (Chiu 2012). Budgets have grown from $115,000, in 1994, to over $2 million, and the organization has contracts with Government of Alberta departments of health, children’s services, education, and employment.

Today, social care is well on its way to being commodified in most Western nations. The desocializing dynamics of the Industrial Revolution that were, at least in theory, contained within the market economy have reached deep into the public systems that were once the preserve of the state. The colonization of the public domain by commercial interests in the late twentieth century is in many ways analogous to the enclosure of the commons in the eighteenth century. What were once public goods in the form of universally accessible human services are being steadily transformed into commercial goods accessible only to those who can afford to pay for them. What we are witnessing in the present day is a new enclosure of the commons: once again, common wealth is transmuting into private profit—a process that is, in large measure, driven by the continuing decline of opportunities for profit making in the market economy. With governments as willing partners, the privatization of public goods and the monetization of social care now beckon as a new frontier from which profits might be wrung—from the provision of health care and clean water to the running of education systems and prisons.

As a result, a number of questions arise. Will civil society find the means to reclaim the social and collective foundations of the public systems that are being abandoned by government and annexed by capital? In an era in which free market ideas and the influence of capital reign supreme within government, can the state be trusted with public welfare? If not—and this is not merely hypothetical—what is the alternative? And finally, can social care be humanized? The sustainability of human services as exchanges of caring relationships is predicated on these questions.

In Canada, as in much of the industrialized West, most of the debate on the changing role of government has centred on government’s retreat from the provision of public services, largely as a response to the deficits of the 1980s and 1990s and the rise of the neoliberal view that the private sector can do better. But changes in social policy and in the delivery of social care have also been fuelled by widespread public discontent with traditional delivery systems. People are fed up with the paternalism, inflexibility, and dehumanizing attributes of state bureaucracies (Finkel 2006). Stories like that of Annie and Al Albo have become all too familiar for far too many people. Combined with the burgeoning public deficits, this has provided a fertile context for the rethinking of public services.

When universal social care systems were first established at the beginning of the last century, first in western and northern Europe and later in North America,
social, cultural, and economic conditions were much different from those that would evolve in the wake of the unprecedented material prosperity generated by capitalism. Throughout most of the 1900s, large portions of Western society were still an accident or a sickness away from total ruin. Basic social security, health care, worker compensation—these programs were designed to provide a basic standard of care for large classes of people. The twentieth century was an era marked by a mechanistic industrial paradigm, an age of assembly line automation that paved the way for the service-based consumer society that has since come to replace it.

This transition to a post-scarcity society has brought with it some fundamental changes, chief among them being the accelerating individuation of society—the strange rise of the individual as someone who is defined solely by what he or she buys and the construction of personal identity as an extension of market forces (Elliot and Lemert 2009). Fuelled by the relentless message of the free market, this individualistic mindset has made choice in the marketplace a criterion of personal freedom and a symbol for consumer culture as a whole. Previously, in the mass industrial age, basic health care and universal social security reflected a model of social care that was geared to large classes of people who lacked these necessities. Social needs were generalized. In the post-scarcity era, in the fantasy age of unlimited personal consumption, needs have become specific and concrete, reflecting the precise needs and preferences of individuals, not classes. With society awash in material goods, people now expect to be recognized and responded to as individuals with respect to social goods and human services. The growing failure of the system to do so provides one means of understanding a possible new future for civil society generally and co-operatives in particular.

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**The Cleaning Solution**

*Celia Lee and Kailey Cannon*

Based in Vancouver, The Cleaning Solution was established in 2004 as a non-profit organization dedicated to employing individuals from the local community who have experienced mental illness and are now ready to re-enter the workforce. The organization provides environmentally

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2 This formulation of general versus concrete characterizations of social needs is derived from Stefano Zamagni, a professor of economics at the University of Bologna. (Lecture, Bologna Summer Program for Co-operative Studies, 2009)
friendly cleaning services for medium-sized businesses, strata and apartment buildings, schools, churches, and government buildings. The Cleaning Solution benefited from a strong “incubating” relationship with the Canadian Mental Health Association (CMHA). In 2011, a performance snapshot document evidenced that The Cleaning Solution showed significant human, attitudinal, and revenue impacts (Demonstrating Value Initiative 2011). In 2014, TCS employed sixty-eight workers (up from five in 2004), who work ten to twelve hours per week (ENP Case Study 2014). Today the Cleaning Solution derives the bulk of its revenue from sales of services priced according to upper-middle market rates in the industry (The Cleaning Solution 2015). Its website reports an 85 percent retention rate for employees. The organization was recognized for a City of Vancouver award in 2012, receiving an honourable mention for Access and Inclusion.


The very notion of standardized systems of care that can be applied to all, regardless of personal preferences, has become something of an anachronism. The reaction against this type of universalism is rooted in the dubious belief that everyone’s basic needs are now met and that we, as consumers, should be able to purchase public goods according to our choice, just as we acquire consumer goods. This belief renders us willing to overlook the dire conditions of many who still struggle in poverty or barely survive on social assistance. Yet it is a point of view that has become characteristic of the consumer age—or at least of that

3 In Canada, despite a growing GDP and federal surpluses, the issues of poverty, homelessness, and hunger show no signs of abating. Between 1989 and 2005, food bank usage increased by 118 percent; in 2005, approximately 15 percent of Canada’s children lived in poverty and rates of child poverty, a powerful indicator of broader social and economic conditions, had remained unaffected for fifteen years (CAFB 2005, 3, 5). In 2013, an average of 833,098 people used a food bank every month (Food Banks Canada 2013, 1).
segment of society that has the money to pay for alternatives and is not prepared to wait in line. This attitude is especially prevalent with respect to those public goods that are amenable to personal preferences and, most especially, to improvement in quality by the expenditure of disposable income: for example, health care, home care, services to the disabled, and public education. This shift in societal attitudes, combined with the inability—or unwillingness—of the state to respond to the change in public expectations, has been a key factor in opening the way for the commercialization of social care, for which there is a growing market. Another critical factor has been the failure of those forces that believed in universal public care to understand this change, to acknowledge its meaning and implications, and to provide progressive responses that were capable of addressing it.

What eventually arose was a twin movement: a push for more pluralistic and private models of care, based on a continuation of free market logic, and a contrary thrust towards non-commercial, social economy solutions. Both approaches call for more pluralism in how care is delivered and more choice on the part of the individual. They differ radically, however, on how this should be achieved, and this difference derives from profound differences in the perception of what social care is.

The privatization of social care is the familiar route of the free market approach. The socialization of care, however, is less well known and less documented. The fact that it is also less lucrative for private interests goes a long way towards explaining why so little attention has been paid to it. Another reason is that for three decades, a relentless campaign to discredit government and the very notion of public services was conducted through all available channels of the media and the academy by the think tanks and private sector promoters that championed the privatization of public goods. The clamour for privatization—particularly in health care—has not subsided. If anything it has grown. There is simply too much money to be made. Despite this, and despite the growing demand for individualized care, public opposition to privatization of universal systems has remained strong. But something is changing. A new interest has arisen in the role of civil society in public welfare and social care.

Over the past twenty years or so, the rise of social co-ops and other forms of social enterprise has gained considerable attention as the glow of privatized care has lost some of its original lustre. In Canada, the failures of privatization in areas such as home care and long-term care were widely reported throughout the 1990s. The ongoing crisis and general instability of the free market model has also undermined calls for its extension in the public sector (Mehra 2005; Roland 2008).
The emergence of social enterprise as a new, hybrid form of social care has been met with growing interest. Within the co-operative movement, the rise of social co-ops has been the most significant change to occur in thirty years. These are co-operatives whose purpose is the provision of social care, not only to their own members but also to the community as a whole. Their primary focus is on services to marginalized populations and to society’s most vulnerable groups. This development signals a change in attitudes towards the market, on the one hand, and the role of government and the public sector, on the other. Privatization is not the only way the market can be used to reform social care. There is a social alternative that reflects a shifting perception of how civil society must now respond to changing times.

ON CIVIL SOCIETY AND THE SOCIAL ECONOMY

The term civil society has now entered—or more accurately, re-entered—the vocabulary of common political discourse. The concept has roots in the political and moral philosophy of the ancient Greeks and the democratic society in which it was first conceived. The stress on the moral life that was a central part of Greek philosophy was always bound up with the concept of civic duty and the pursuit of the just society (Plato 2007). For Plato, the ideal state is one in which people dedicate themselves to the common good; practice civic virtues of wisdom, courage, moderation, and justice; and perform the social and occupational role to which they are best suited. Aristotle (2000) held that the “polis,” or city-state, was an “association of associations” and the social reality that made political life possible. For these thinkers, there was no distinction between state and society, and the idea of civil society as a political concept was profoundly influenced by the democratic institutions of Athens: civil society was made possible by the fact that individuals were not mere subjects of an absolute power but were independent actors with the freedom to form horizontal bonds of mutual interest with others and to act in pursuit of this common interest. This was the essence of citizenship, and the link between civil society and democracy was to remain a defining feature of the term. One subsector of civil society comprises those activities carried out by organizations that provide a vast range of goods and services through collaboration—by people working together to realize mutual, and collective, goals. It is this economic dimension of civil society that constitutes the social economy.

With the rise of interest in civil society and the social economy, the market view of society as composed of two sectors—the private and the public—is now
being challenged. The notion of the social economy calls into question the narrow reading of economics as a dimension divorced from society. It enlarges classical economics to include the social relations that accompany and underlie the creation and distribution of wealth and situates economic behaviour within the wider compass of social reality (Mendell 2003).

For both of these conceptions—civil society and the social economy—the notions of reciprocity and mutuality are fundamental. They are also essential for understanding the means by which a new view of social care—a civil view—might be developed as a more humane alternative to current systems. And it is through the lens of reciprocity and mutuality that we might glimpse what it means to move from the paradigm of the corporatist welfare state to that of a caring society.

THE PRINCIPLE OF RECIPROCITY

Reciprocity is the social mechanism that makes associational life possible. Reciprocity rests on the expectation that a kindness will be returned, in a system of mutual obligation and voluntary exchange. When I willingly give something of value to someone, be it a material object or a favour of some sort, I do so on the assumption that the other person will at some point be willing to do the same for me, thereby acknowledging my gift. If, for example, my neighbour, Fred, asks to borrow my lawn mower, and I loan it to him, my expectation is that Fred will recognize that he now owes me a favour. If I subsequently ask Fred for something of roughly equivalent value, and he refuses, the basis of reciprocity falls apart. No more loaning of the lawn mower to Fred. Moreover, if Fred’s failure to reciprocate forms a pattern and becomes known, his reputation will suffer and others will stop extending favours to him as well. The willingness to reciprocate is a basic signal of the sociability of an individual. Taken to an extreme, the complete unwillingness of individuals to reciprocate is tantamount to severing the bonds between themselves and other people. Reciprocity is thus a social relation that contains within itself potent emotional and even spiritual dimensions, elements that account for an entirely different set of motivations within individuals than those underlying behaviour in the classical sense of maximizing one’s utility as a consumer.

Reciprocity and the promotion of mutual benefit animate a vast range of economic activities that rest on the sharing and reinforcement of interpersonal attitudes and values that constitute essential bonds between the individual and the human community. When reciprocity and mutuality find economic expression in the exchange of goods and services among people and between and within
communities, the result is the social economy. Examples range from the creation of “friendly societies” in the 1800s for the provision of various services, including burials, to the promotion of neighbourhood safety through organizations like Neighbourhood Watch today.

What is exchanged in reciprocal transactions is not merely particular goods, services, and favours but, more fundamentally, the expression of good will and the assurance that one is prepared to help others. This exchange is the foundation of trust. Consequently, the practice of reciprocity has profound social ramifications and entails a clear moral element. Reciprocity is a key for understanding how the institutions of society work. But it is also an economic principle with wholly distinct characteristics that embody social as opposed to merely commercial attributes. For one thing, the use of reciprocity increases both its value and the social capital on which it rests. Each instance of reciprocity strengthens the bonds of trust and mutuality that make it possible. An increase in the number and operations of social economy organizations like co-operatives and community service organizations raises the capacity of a community to care for its members. For the provision of humane systems of care, this capacity is at the core of sustainable social care.

Finally, reciprocity is egalitarian—it’s operation presupposes a direct relationship of equality between the individuals involved. It is very different from altruism and charity, where the giver may have no relation to the receiver and where there is a clear asymmetry of power. In the matter of social care, this equality of power has profound implications. And it is this egalitarianism that is characteristic of social co-operatives.

SOCIAL CO-OPERATIVES

The rise of social co-operatives represents a new frontier in the shifting boundaries of public, private, and commercial spheres. Pioneered in Italy during the 1980s, social co-ops embody the collectivist and co-operative traditions of the past, along with a new focus on individual choice and the use of market forces that until now have been hallmarks of neoliberal approaches to social policy. The blending of these elements makes social co-ops a kind of social experiment that places civil society at the forefront of social service reform. Based on models of care that embody the strengths and values of civil society, social co-ops offer an alternative to both state and market systems and are forging new roles for civil society and government. And while the debate in Italy concerning the role of the state has raged, as it has in all the Western democracies, the practical outcomes of
social co-ops within Italy are indicators of where the future of social policy reform may ultimately lie.

In Italy, more than 14,000 social co-operatives now provide social services throughout the country. In 2008, they employed 317,000 individuals, including more than 40,000 disadvantaged persons (Carini and Costa 2013). This represented fully 23 percent of the non-profit sector’s total paid labour force, even though the co-operatives constituted only 2 percent of non-profit organizations. The economic turnover of social co-ops in 2011 was over €8.9 Billion, with 402,900 employed and more than five million people using their services. (Carini and Costa 2013). From 2007 to 2011—the period when the financial crisis made itself felt—employment in Italy fell by 1.2 percent, while the number of employees in private enterprises decreased 2.3 percent (Censis 2012). In contrast, the number of employees in social co-operatives increased by 17.3 percent, with a growth of 4.3 percent in 2012 alone (Carini and Costa 2013). Today, social co-ops are a central aspect of Italy’s social service system. In the city of Bologna, 87 percent of the city’s social services are provided through municipal contracts with social co-ops.

In 1991, legislation was introduced to recognize and regulate the increasingly important role that social co-operatives were playing in the provision of social care in Italy. It was the first social co-op legislation in Europe. As described in Law 381/91, social co-ops have as their purpose “to pursue the general community interest in promoting human concerns and the integration of citizens.” The social co-operatives in Italy aim to benefit the community and its citizens rather than to maximize benefits solely for co-op members. Italian legislation also acknowledges the affinity between public bodies such as municipalities and health boards, on the one hand, and social co-ops for the promotion of public welfare, on the other, and it emphasizes the possibility of collaboration between them. In consequence, an important symbiotic relationship has developed between these co-ops and the municipal bodies that are primarily responsible for contracting their services.

The establishment of social co-ops in Italy has resulted in improved access and a net increase in the variety and quality of social care (Borzaga and Depedri 2012; Thomas 2004). According to leaders within the social co-op movement in Italy, this increase has not been at the expense of civil service jobs, which was a major concern of the public sector unions. Instead, the public services have been able to concentrate on areas where state regulation, oversight, and centralized information and distribution can benefit the system. Social co-ops focus on the front lines

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of care where service design and relationships between caregivers and users are paramount in determining the quality of care, two examples being personal care for the elderly and the treatment of people with addictions. As a result, the relative cost of care in areas where social co-ops have been operating has declined while the quality of care has improved. Job satisfaction among employees working in social co-ops is also higher than that reported in either the public or private sectors, despite the fact that wage rates are generally lower (Bacchiega and Borzaga 2003; Borzaga and Depedri 2005). Why is this so?

The reasons flow from the nature of social care itself and the ways in which co-op models require caregivers and users to make explicit and reinforce the human relations that underlie care. The principles of reciprocity, equality, and accountability are inalienable qualities of humane care. They are also organizational attributes of co-operative organizations. They are not, however, attributes of either state systems or private for-profit systems.

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**Free Geek**

*Kailey Cannon*

A non-profit organization pursuing social and environmental goals, Free Geek Portland was founded in 2000. Since then twelve additional autonomous Free Geek organizations have sprung up in the United States, Toronto, and Vancouver. Free Geek has a dual mission: to reduce the impact of e-waste through refurbishing, reuse and recycling and to provide computer technology training to all people in the community at low or no cost (Free Geek Vancouver 2013). Its members are concerned about a widening “digital divide” (unequal access by the poor to computers and computer training) and an alarming increase of toxic e-waste destined for developing countries.

In a 2009 study, Free Geek Portland alone had provided more than fifteen thousand refurbished computers and had recycled two thousand tons of e-waste (Johnson 2009). Fosdick argues that refurbishing gets

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5 Taking into account both the costs and benefits of social co-ops to the public sector (costs being public subsidies and fiscal advantages and benefits being taxes paid by both the employed workers and the co-operative and a decrease in the demand for social and health services by disadvantaged workers), public authorities save more than €5,000 per capita annually (Borzaga and Depedri 2013).
around the need for a new computer, and the chemicals and resources used to build it, which he estimates at ten times the products’ weight (2012, 58). Most Free Geek groups generate enough revenue from sales of computers and parts in their thrift stores to be financially independent, but they occasionally receive donations and grants as well. Through its Adoption Program, Free Geek gives its clients the option of volunteering labour in exchange for a free computer. In Vancouver, the Free Geek Build Program requires a would-be purchaser to learn how to refurbish computers. They refurbish six in order to keep the sixth computer for free. Some Free Geek groups also have a special internship program through which they offer “skills training, letters of reference, professional feedback, and resume assistance” in exchange for interns’ unpaid work. Others support the broader community through a Hardware Grant program and donate refurbished computers and equipment to non-profit organizations.


THE CASE FOR A CO-OP APPROACH TO SOCIAL CARE

There are three compelling reasons to promote co-operative models for the delivery of social care. The first has to do with the nature of social care and the kind of models that are best suited to deliver that care. This concerns the question of relational goods. The second reason pertains to the relation of organizational structure to service design, delivery, and efficiency. The third reason is the need to humanize care through the socialization of its content and its manner of operation. The democratization of care is essential.

*Relational Goods*

The “discovery” of relational goods is one of the truly paradigm-shifting developments in recent economic analysis. Unlike conventional goods, relational goods
can only be enjoyed jointly with others, not by an individual alone. A relational good is a kind of public good in that it is anti-rival—that is, unlike a rival good whose use by one consumer excludes its consumption by others, a relational good is freely available to all and the amount available is not reduced by its consumption (Weber 2004). As a consequence, participation in the consumption of relational goods actually benefits both the participant and others and increases the value of the good itself. Examples include the collective joy of an audience experiencing a musical performance, the generalized laughter at a comic film, and the surge of energy in a stadium when one side’s team scores a goal. The greater the number of people who enjoy a relational good, the greater its utility. On a more intimate level, relational goods acquire value through sincerity, or genuineness—they cannot be bought or sold. Friendship and caring are relational goods, and they are their own reward. They are things whose sale would immediately destroy their worth.

In human services, relational goods are services that are characterized by the exchange of human relations. Because the quality of the personal relationship lies at the core of the exchange between the provider and the recipient, relational goods can be optimally produced only by the provider and recipient acting together. Beyond this, relational goods have also been defined as the value of the relationship itself, over and above the particular goods or services that are produced (Uhlaner 1989). These qualities are at the heart of social care. Reciprocity, the entering into a relationship of mutual benefit on the basis of equality, is the foundation for a type of care in which both caregiver and recipient share in the generation of care as a human relation, not as a purchased commodity or a charitable offering from the strong to the weak.

Consider, for example, care for a person with a disability. A reciprocal relationship offers recipients the means to determine how their care will be provided; they have a say in determining when the service would be offered, who the caregiver will be, what the content of the care will be, and how their personal preferences and needs can best be served. Reciprocity in social care entails sharing among equals: sharing of information, responsibility, and power. Reciprocity is the source of dignity for the user, vocational gratification for the caregiver, and mutual accountability for both. It is the mechanism by which a society makes manifest its internal solidarity and the mutual responsibility of its members. Without the democratization of care through the sharing of power and the reordering of relationships on the basis of equality, none of this is possible. Co-operative structures in which power is shared between provider and user make this possible.
Services such as education, health care, and care for people with disabilities are “social” because they are not merely commercial commodities. Based on social relations, they are wholly different from the for-profit exchange of commodities that characterizes commercial transactions. This is why referring to such services as “products” or to the recipients of social care as “clients” is so profoundly false. It is the unthinking impulse in a market society to commodify a human, and social, relation. Neither state bureaucracies, which depersonalize social service recipients, nor private sector firms, which instrumentalize recipients as a source of profit, can ever be suited to the provision of relational goods.

**Organizational Structure**

To be clear, I am not claiming that private sector firms are incapable of attending to the caring aspect of a social service. I am saying that the cultivation of the relational aspect of care, what is in essence its human factor, is not generally in their interest since it means investment in time, and therefore money, and a private firm’s objective function is to maximize profits. The same problem of conflicting priorities undermines private firm investment in employee training and professional development. Although such investment tends to increase service quality, employment standards, and staff morale, it does not, at least in the short term, increase profits. In both cases—state and for-profit delivery—what suffers is the quality of a caring and reciprocal relationship, which is at the heart of the service being produced. This shortcoming of conventional delivery systems has little to do with the intentions that lie behind these models of social care. What is at issue is the faulty physiology of the structures and economic principles underlying the provision of care. Neither the redistributive economic logic of government nor the commercial exchange logic of the private sector can do justice to the reciprocity principle that is the basis of social and relational goods.

Organizational form is fundamental to the relationship between the content of social care and the systems that provide it. In state-delivered systems, social care is properly perceived as a civic right that should be available to all citizens equally. But equality in service delivery rarely translates into social care that is fair, or appropriate, or responsive to the unique needs of individuals. What is fair for all is often grossly unfair for individuals. Universal access through state systems requires that services be designed for application to large classes of users, not to individualized cases. Inflexibility, remoteness, and regimentation of care are a necessary consequence, along with the inevitable dehumanizing and impersonalizing effect of bureaucracy.
These characteristics of state-delivered services are well known, both academically and in the lived experience of countless individuals who have had to endure the inefficiencies and indignities of bureaucratic systems. An alternative to both private care and traditional government delivery is essential if the public nature of health and social care is to be protected and if these services are to be responsive to people’s actual needs and preferences. With both the right models reflecting the inherent qualities of care as an exchange of relations among people and a public policy that promotes such an approach, the provision of care can be extended throughout society at a local, community level. In addition to radically transforming the provision of care, such an approach has the potential to transform society as well.

Co-op models for the production of 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 usually associated with a private sector service. For example, social co-ops have played a major role in improving both the quality of home care and the working conditions, wages, and professional competence of home care givers. An outstanding North American example is Co-operative Home Care Associates in the South Bronx, which, according to the CHCA website, employs more than two thousand staff and generates $60 million in home care services annually. Some social co-operatives provide life-skills training and employment to people with intellectual disabilities, again simultaneously offering a public good and individual choice. In many such co-ops, individuals not only find meaningful employment; they also sit on the board of directors and, with support from personal advocates, have a say in how the enterprise is run. The effectiveness of these organizations is rooted in the structure of co-operatives as user owned and operated. Like public services, co-operatives have a mandate to serve the collective needs of member-owners. In the case of social co-ops, this aim extends to the community as a whole, but the scale of delivery is much smaller, 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 provides the choice with respect to service that is characteristic of the private market without the constraints associated with having profit as the primary goal.

In the case of health services, co-operatives have pioneered a patient-focused approach to health care that is a direct consequence of user control over the design and delivery of these services. Health co-ops in Canada provide community-based care to over one million Canadians. In BC, health co-ops now operate in Victoria,
Nelson, and Mission, with interest growing in other communities as well. These co-ops were started to provide communities with the kinds of health services that had been either withdrawn by the Province or never provided to begin with. Other key human services provided by co-ops include funeral care. Across Canada, there are thirty-nine funeral co-ops, with twenty-five of them located in Québec. Everywhere they operate, funeral co-ops provide exemplary service to their members at a considerably lower cost than private funeral services.  

In the provision of social care, social co-ops and other forms of social enterprise have increased the range of services available to citizens while simultaneously containing the costs for the provision of these services by the state. The co-op model has been most effective when it is developed as a complement to, not a substitute for, public services. In those places where social co-ops are most advanced, their proponents advocate strongly for government to continue playing a central role in the funding and regulation of public services.  

The case of social co-ops in Italy shows that the multistakeholder structure of social co-ops is a key factor in lowering costs, increasing service innovation, addressing market failures, and responding to the changing needs of individual users. The involvement of stakeholder groups in the production and delivery of services confers advantages that differentiate these co-ops from conventional non-profits, private firms, and government agencies (Bacchiego and Borzaga 2003). Unlike non-profits and private firms, which are controlled primarily by those who receive monetary benefits from the organization (employees in non-profits and investors in private firms), social co-ops are controlled by a variety of stakeholders, allowing costs to be contained. The control rights exercised by consumers and volunteers moderate the distribution of profit and the rise of costs, and so social co-ops can provide services more efficiently. The involvement of consumers and volunteers in the delivery of services also lowers the cost of production. Moreover, the involvement of multiple stakeholders reduces the traditional costs.

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6 According to Alain Leclerc of the Federation of Funeral Co-ops, the average cost of a funeral in Québec is about $5,600, whereas a funeral arranged through a co-op generally costs less than $4,000 (presentation at BC Co-operative Association, 2011). For more information on funeral co-operatives in Québec, see Fédération des coopératives funéraires du Québec (http://www.fcfq.coop/en/funeral-cooperatives/). For an example of a funeral co-op in Alberta, see Serenity Funeral Service (http://www.serenity.ca).

7 This is the common position adopted by social co-op activists for example in Emilia Romagna and by the Lega Co-operative e Mutue and Confcooperative, the two largest co-operative federations in Italy.
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, spurs innovation in service design, and raises the levels of transparency and accountability in the organization.

Social co-ops are better than government at coping with insufficient budgets, which is a key market failure of government services. Combining public and private funds that are used to capitalize services is a key strategy of social co-ops for distributing costs in a way that subsidizes those who are less able to afford the services. Forty percent of Italian social co-ops have introduced measures to distribute resources in such a way that users are not required to pay the full cost of services provided to them (Borzaga and Depredri 2012). Some services are provided free of charge to all users (48% of co-ops) or to the poorest users (36%). This extremely important distributive function—which has a profoundly beneficial effect on the community, both by lowering poverty rates and by saving costs to the state—is made possible by the unique organizational structure of the co-ops, by the high levels of trust they generate, and by their capacity to mobilize resources from volunteers, donations, and intrinsically motivated workers who donate overtime to the organization (Borzaga and Depredri 2012). The involvement of multiple stakeholders also limits the monopoly market control of government services and the attendant constraints on the ability of users to access services that actually reflect their preferences.

Since social co-ops are not as limited in how profits are distributed as are conventional non-profit organizations, which are prohibited by law from distributing profits to those who exercise control over the organization, they are better equipped to raise capital from members, funders, and other stakeholders. They are also able to provide a limited return on 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.

Finally, social co-ops play a powerful role in strengthening the social determinants of health in a community. The alleviation of poverty, the reduction of inequality and social alienation, the expansion of social solidarity and social capital, and the improvement of access to services among the vulnerable and marginalized are all measurably affected by the prevalence of social co-operatives (Borzaga and Depredri 2012).

Taken together, these structural features of the co-op model greatly increase its sustainability, not only because they reinforce a humane quality in the kind
of social care provided but also because they strengthen the economic basis for
its provision.

**Democratizing Care**

Social co-ops, like all co-operatives, are defined by the fact that they grant con-
trol rights to stakeholders and members. In this sense, they are distinct from non-
profits that are essentially defined by the constraint on distribution of profits, as
noted earlier. In a co-operative structure, it is the element of member control and
ownership of the co-operative that defines both the culture and the operations of
the organization. In those social co-ops where the service users are also members,
the operation of control rights has the capacity to transform the user from being
merely a passive recipient of care—an *object* of care systems—to being a protagon-
ist in the design and delivery of the care—an active *subject* in the care relationship.
Social care becomes a shared outcome between caregiver and care receiver. This
element of personal control is fundamental to the reform of social care systems,
particularly for those who are most dependent—people with disabilities, the poor,
and the marginalized.

The reform of social care, its transformation into a humane system of social
relationships, requires at minimum its democratization. This democratizing ele-
ment is the central reason why co-operative forms of social care represent such
a strong instance of sustainable human services—they embody the reciprocal
nature of care while transforming the institutional structures that provide it.

**SCALING AND THE PERILS OF SUCCESS**

Since their inception, social co-operatives in Italy have been able to sustain a rate
of growth and diversification that is a testament to the robustness and the innova-
tive power of the model. The country’s social co-ops have been able to develop
both horizontal and vertical networks that have enabled them to greatly expand
their capacity for service delivery at local, regional, and inter-regional levels.
Through the development of multi-layered consortia, the co-ops have maximized
their ability to lower operating costs, to distribute resources, to share knowledge,
and to innovate in the design and delivery of services through their close affiliation
with other co-ops and the diverse groupings of stakeholders that support them.
Indeed, this is one of the characteristic features of the co-operative movement in
Italy and a key factor in its continued growth when compared to the private sector
(Menzani and Zamagni, 2010).
In absolute numbers, social co-operatives increased from a little over 2,000 before the passage of Law 381 in 1991 to nearly double (3,900) by 1996, and reached 7,363 in 2005 (Euricse 2009). This growth continued until at least 2008, when 13,938 social co-operatives were registered, with about 8,000 of these providing social services and 5,000 providing work integration (Andreaus et al. 2012). Therefore, about 20 percent of the social co-operatives that are currently active emerged before the law on social co-operatives was enacted. What is also interesting is that recent research shows a relatively positive economic situation among Italian social cooperatives despite the global economic and financial crisis. From 2008 to 2011 the co-operatives increased their overall turnover by 20.4% and their total assets by 28.4%. In addition, employment data shows a positive trend with a variation from 2008–2011 of nearly 10% (Carini and Costa 2013).

Nevertheless, the global financial crisis has taken its toll. The number of social co-operatives increased by only 324 in 2009 and 98 in 2010; meanwhile, 31 fewer co-ops were registered in 2011. This trend relates not only to the market crisis but also to the fiscal policies of the central government—which has decreased funding to local authorities, those ultimately responsible for the contracting of services to the co-ops—and to the need for social co-ops to merge in order to achieve economies of scale (Borzaga and Depedri 2012).

A number of issues are thus highlighted by these data. First, while social co-ops have flourished in Italy, their strength has been predicated on a combination of both intrinsic strengths and the public policies of government. The enactment of empowering legislation that recognizes and validates their social role is a key factor in their growth. The availability of public subsidies through supportive tax policies and the provision of public service contracts are essential to their operation. Unfortunately, this makes social co-ops extremely dependent on supportive government policy. If public funding for their services is cut, they suffer—as demonstrated in Italy by the decline in growth following the fiscal crisis in 2008.

Second, the need for increased scales of operation—often required by the scale of services demanded by public contracts—has generated the growth of both consortia and individual co-operatives, and this can be at odds with the need for close contact and interaction with members and users at local community levels. The charge has been made that the success and size of some social co-ops has alienated them from the kinds of interactions and community relations that are fundamental to the health of democratically governed organizations and the specific needs of the communities they are meant to serve. This, too, is a consequence of
government policy, declining public funding, and the demands of surviving in a capitalist economy.

Finally, while state policies have provided social co-ops with both organizational and financial instruments that enable them to capitalize their operations, the model still relies on the use of public and private forms of capital that are subject to the vagaries of a capitalist economy. Perhaps this is unavoidable. But the exploration of social market models and non-capital forms of exchange that reflect and reinforce the co-operative and reciprocal nature of the social economy in general, and the mission of social co-ops in particular, is an issue that demands serious study if the social co-op form is to realize its potential.

BEYOND DEFENSIVENESS

Despite the role that social co-ops in Italy have played in social care reform in that country, for the most part, organizations within civil society as a whole have been very reluctant to engage government around the question of remaking social care. For two decades, this role has been controlled by private sector groups in the advancement of their own commercial interests, and—perhaps—as part of a genuinely held belief in the superiority of free market models. What this has meant is that civil society, and the political Left generally, has been placed in the position of defending a dysfunctional status quo. Labour, in particular, has been unwilling to countenance any move that can be construed as weakening the state role in public services—and by extension, compromising further the jobs of civil servants. In Canada, as elsewhere, the ripping up of collective agreements and the downsizing and subsequent loss of thousands of public sector jobs has taken its painful toll. Among its crippling effects is a fortress mentality on the part of organized labour. But the uncomfortable question must still be asked—if labour’s interests, in Canada at least, are driven solely by the fact that the bulk of their members and dues payers are in the public sector, how can they be a force for a reform of social care that questions the received role of the state?

On the whole, the posture of the political Left and of those segments in civil society that have become active in this issue is defensive—they constitute a conservative force in opposition to change. Given the damage done to public services in the name of “reform” over the last two decades, this is understandable. But the continuing defence of the state monopoly model is untenable, short-sighted, and revealing of serious weaknesses. The short-term interest of labour is one issue. A second is the dependence of many civil society institutions on government.
Civil society, despite its formal distinctions from the state, remains a dependent sector—in many ways, a client sector of the state.

Too many non-profits and NGOs, and the leadership they employ, are kept in operation solely by government funding. For example, more than 50 percent of the cost for services provided by voluntary non-profit social welfare agencies in the United States is funded through government purchase-of-service arrangements. Government funds account for 65 percent of the Catholic Charities budget, over 60 percent of Save the Children, and 96 percent of Volunteers of America (Gilbert and Terrell 2005). The same is generally true in Canada. This absence of autonomy has undermined these organizations’ capacity to represent, and fight for, the interests of civil society as a sector with its own interests apart from those of the state. At a time when government has all but erased the distinctions between private and public interests, state dependency threatens civil society’s capacity to demand reform of public institutions in accordance with the values appropriate to those institutions and the public interest. Failure to take full measure of the issues at play and to show leadership on what is perhaps the defining question of public policy at the dawn of the twenty-first century has left the field precisely to those forces least concerned with the public interest.

In a move that should serve as a wake-up call for the Left, the case for a civil approach to human services is now being led by conservatives. The Big Society experiment now unfolding in Britain has become a central tenet of the Cameron government even as it slashes public funding for everything from health care and education to public transport and postal services, all in the name of austerity. Using arguments for increased user control, democratic accountability, service flexibility and innovation, and the empowerment of citizens and local communities, Big Society proponents are asking civil society to take up the challenge for the production of human services and a vast range of government programs. The intellectual case for this approach has been made by Phillip Blond, a former lecturer in philosophy and theology, who has argued that it is only conservative values that are capable of protecting the social bonds of community that are undermined both by the paternalism of the state and the rampant individualism of liberal ideology. His argument for an alternative to statism, on the one hand, and privatization, on the other, has provided intellectual cover to the Conservatives, who are now cutting public services while mouthing ostensibly progressive values. To support this approach, Blond rewrites economic and political theory to deny the role that both socialism and liberalism have played in the development of civil values, including an understanding of social care as a collective responsibility. He also conveniently
glosses over the appalling historical record of political conservatism, particularly in Britain, as the primary obstacle to the emergence of public systems of care for the vulnerable (Blond 2009).

But the most disturbing question is this: Why is it that the civil case for the provision of social care has come from conservatives and the political Right? How is it that once again, the terms of this fundamental debate about social care have been set by those who have historically been least committed to it? Without question, progressive forces have once again been outflanked on a central point of public policy, and it is merely a question of time before the same progressive arguments for the reform of public services being used in Britain will be appropriated by the forces of conservatism in Canada and the United States.

Already, the Harper administration in Ottawa has undertaken a wholesale review of the charitable sector, including a rewrite of charity legislation to reflect a more “entrepreneurial” and market-driven approach to social giving. In his 2014 budget speech to Parliament, Finance Minister Jim Flaherty rationalized the introduction of additional restrictions on the operations of Canadian charities with the claim that the changes are intended to curb money laundering by foundations with ties to terrorist organizations (Fekete 2014). Not a scrap of evidence has been presented to justify this claim. Coupled with the selective auditing of those environmental groups that have opposed the government’s oil policies, these actions further intensify the demonization of the charitable sector by the Harper government. As public confidence in government and the corporate sector plummets, Ottawa is vandalizing what remains of public trust in those civic institutions that are now the last outpost of civic values in this country. In this, the Harper administration is taking its cues from the Cameron government in Britain. And, as in Britain, those sections of civil society that have historically been most committed to improving social care for the most vulnerable are deeply skeptical of the outcomes—and for good reason. The Harper Conservatives were defeated in late 2015 by Justin Trudeau’s Liberals, who campaigned on government trust in civil society groups.

Despite this, the sustainability of human services and what I have termed the “relational content” of care is deeply related to the emergence of new, civil forms of social care that complement public systems. Both forms are necessary. And for those who advocate for a more humane alternative to the status quo, it is not enough to demand that civil society play a larger role in the protection of existing social services. If alternative models are to be viable, new modes of social care that embody the attributes of reciprocity, accessibility, and accountability must
be implemented. In this, Blond’s (2009) diagnosis is correct. But what is lacking is the blend of organizational form and public policy that can combine empowering and socializing delivery models, on the one hand, with new economic and power-sharing relations with the state, on the other. What is needed is a new conception of market forces with respect to social care and relational goods. In this context, we can at least thank the British Tories for showing that this is possible, even if the underlying motives are suspect.

Civil society finally has to reflect upon and articulate civil solutions to the challenges of social care in a new era. This entails the liberation of civil society from its dependency on the state—the maturation of the sector as an independent social force—and the creation of a true civil economy for social and relational goods: that is, a social market suited to the unique operations and requirements of the social economy. Only in this way will the overwhelming power and influence of the capitalist market be brought into balance with civil values. An autonomous civil economy based on reciprocity and civil values would also make possible the political power necessary to negotiate a new social contract for a new age.

CONCLUSION

There seems little question that the potential impacts of the policies and practices outlined above—impacts related to structural change, market-based activity, scale, networking, and challenges to existing regulatory systems and capacity building—have profound implications not only for human services but for sustainability broadly conceived. The reconstruction of human services along civil lines entails a deepening of the relations among social economy organizations and a convergence of ideas and practices that are based on a long-term vision for humanizing social care by embedding the practice of reciprocity and expanding democratic control by citizens. For strengthening the social economy and for promoting social care systems that both sustain and enhance the human element of care (and that begin to introduce environmental factors related to care), a civil model of social care is fundamental. In this sense, the approach outlined here represents a strong social economy framework for interpreting the issue of sustainability with respect to human services. A focus on civil systems of social care that activate the key principles of reciprocity, mutuality, and democratic control results in the transformation of human services at a broad institutional level while simultaneously expanding the scale, coherence, and capacity of the social economy itself.
The critical question that remains is whether the key institutions of civil society and the myriad of organizations that compose the social economy can find common cause to advance a vision of social care that is both progressive and transformative. This poses a political challenge as much as a moral one. Effecting such change entails a radically different conception of civic rights, of the supportive role of the state in protecting those rights, and of the inherent and inalienable right of citizens to protect the collective public goods that have taken generations of struggle to achieve. And yet it is clear that the status quo is not working. If those who seek transformation are able to set the terms of the debate for change, they will win the day because as the poet said, “The Times They Are A-Changin’.” But certainly not in the way we had hoped. Just look at Britain.

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