

Social Co-ops and Social Care

An Emerging Role for Civil Society

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Introduction

Over the last twenty years, a profound change has taken place in the relationship between citizens and their governments. In the western democracies, the gradual transformation of social care into a commercial commodity has fundamentally altered the role of government as the primary provider of social care and public welfare. This change in the relations between the state and the citizenry has been marked by starkly different perspectives, deep conflict, and the radical realignment of social and state institutions.

Nowhere has this conflict been more contentious than in the debate surrounding the role of government and the nature of public services.

In Canada, most of this debate has centered on the retreat of government from the provision of public services, largely as a response to the deficits of the '80s and '90s, and the view that the private sector can do better. But changes in social policy and the delivery of social care have also been fuelled by deep discontent with traditional state delivery systems by many sections of the public.

In the wake of these changes, there has arisen a new interest in the role of civil society and its relation to public welfare and social care.

How to respond to these changes has also been one of the greatest challenges to face the Left in Canada and abroad in a generation.

This discussion examines the nature of social care and its relation to civil society, and takes a look at how the co-op model has been at the forefront of an emerging role for civil society through the creation of social co-operatives in Italy and elsewhere.

We also examine the implications of this emerging role for the traditional Left in Canada, and the political perspective that has provided the strongest critique of the "reforms" that have been introduced by neo liberal governments both in Canada and abroad.

Civil Society

Recently, the term "civil society" has become a kind of catch phrase that covers a wide range of meanings. This has been confusing, and some careful definitions concerning civil society and the related but distinct term of "social economy" are probably helpful.

In its broadest sense, civil society is the social impulse to free and democratic association, to the creation of community, and to the operations of social life, which includes politics. This is the sense of civil society that is used by writers such as Vaclav Havel.¹

Within civil society, many of these social operations are carried out by organizations that are created in order to accomplish things that people can do better by acting together than alone. They constitute that sector which is neither the state, nor the commercial market, and which includes non-profit and voluntary organizations, charities, and co-operatives. This has also been described as the third sector, or the social economy.

¹ A Speech by Vaclav Havel President of the Czech Republic on the Occasion of "Vaclav Havel's Civil Society Symposium"

Vaclav Havel's ideas and his Civil Society conception Macalester College, Minneapolis/St.Paul, U.S.A., 26 April 1999

From an economics perspective, the social economy is more precisely described as those organizations and social institutions that operate on the principle of *reciprocity*, the production and exchange of goods and services for mutual benefit.

Reciprocity is the defining element of civil society and it lies at the foundation of all forms of voluntary co-operation.

Social Co-operatives

History and sector profile

In the broader context of the changing role of governments, the emergence of social co-operatives as instruments of social care is one aspect of civil society's response to the crisis of the welfare state.

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 the north of Italy, in those regions where co-operatives and civil society are traditionally strongest, 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 the values of civil society as a clear alternative to both state and market systems.

The rise of social co-operation in Italy was not primarily a result of the decentralization and contracting out of services by the public authorities. By and large, public sector workers were not displaced because of the growth of social co-operatives.

Rather, social co-operatives 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.

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 6,000 social co-operatives providing social services throughout the country. Social co-ops employ 160,000 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.²

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 a key source of self-fulfillment. This sense of job satisfaction is directly related to the perception that they work in an environment of shared values and their status as decision-makers in the design and delivery of the co-operative's services.³

Pay scales in social co-operatives compare favourably with those of public sector employees, with managers receiving above average wages. Professional training and career advancement

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

³ Ibid

is also a vital area where workers of social co-ops report higher levels of satisfaction than their counterparts in the public and private sectors.

The vast majority of workers in social co-operatives are unionized or are represented by established trade unions.⁴

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 85% of that city's social services are provided through social co-ops.

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”.

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.

Compared with traditional non-profits, 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.⁵

⁴ Note: In Italy, even workers that choose not to join a labour union are entitled to representation in their workplace.

⁵ Ibid

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.

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 fundamental 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 a vis its support of public services, and to hold the state accountable for the provision of these services to the public.

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.

The Nature of Social Care

The emergence of social co-operatives raises fundamental questions about the nature of social care and the appropriate roles and responsibilities of civil society, the state, and the commercial market.

From both a social and an economics perspective, the most relevant response to the crisis of social care systems revolves around the notion of “relational goods”, and what kinds of organizations are best suited to deliver such goods.

Relational goods are defined as those goods such as care giving, which are services to persons and which are characterized by the exchange of human relations. In relational goods, the quality of the personal relationship lies at the core of what is exchanged between the provider and the recipient and can be optimally produced only by the provider and recipient *together* (S. Zamagni).

This of course, applies to the unique nature of social care. Services such as education, health care, and care for people with disabilities are “social” in part, because they are not merely commercial commodities. They refer to social relations that are apart from the exchange of commodities for profit that characterize commercial transactions.

Neither state bureaucracies, which tend to depersonalize social service recipients, nor private sector firms, which see recipients primarily as a source of profit, are suited to the provision of relational goods.

To be clear, it is not claimed that private sector firms are unable to attend to the caring aspect of service functions. Rather, the point is that it is not in their interest since their objective function is to maximize 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.

Moreover, this shortcoming of conventional delivery systems has relatively little to do with the *intentions* that lie behind these models of social care. What is at issue is the *physiology* of the structures that are used to provide care to people.

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 truly responsive to the unique needs of individual people.

State bureaucracies are ill suited to the provision of individualized care. Delivery systems are typically inflexible, remote, impersonal, and adjusted to uniform standards that may have little to do with what real people actually want. In addition, authority is vested at senior management levels with little or no power at the level at which caregiver and care recipient meet. The result is that people are often dissatisfied with the content of the care and with the way they are treated.

Also important is the fact that as societies develop and become more affluent and complex, the nature of people's needs and expectations also changes. The sense of personal identity and individuality increases and needs become more specific and concrete, as opposed to generic and abstract.

To illustrate, forty years ago, it was sufficient for Canadians to receive a health service that covered basic health needs, because many people had no health care at all. Today, people expect more.

They expect not only higher standards and greater choices for the care they receive, they also demand a say in how that care is offered. The inability of a state health system to address this change in people's expectations can undermine the viability of an irreplaceable public health service.

Finally, the provision of social care through state bureaucracies is inefficient. The state mechanisms that are required to design, develop, disburse, and monitor resources for social services are an additional cost to the actual content of care. This is not even to consider the drawbacks of centralized decision making in an area where the best source for informed decisions is the actual recipients and providers of care.

The problems with for profit solutions have been repeated often. The two most obvious issues concerning market approaches to care are the inevitability of market failures and the commodification of social relations.

Market failures arise from the fact that private entrepreneurs will only enter a market for social care if they perceive that there is a profit to be made. The moment the prospects for profit taking reduce to zero they will leave the market irrespective of the needs of those relying on the service.

A further consequence of market approaches to social care is that providers will always be liable to shortchange the quality of service to maximize profits. Services may end up costing more or declining in quality, and sometimes both. In the case of services that cost more than public subsidies may provide, private care excludes those that cannot afford it, usually those that need it most.

The commodification of care is a deeply social and ultimately, moral issue that disturbs many. It is seen as a corrosion of social values that are fundamental to progressive and caring societies. And, it seems clear that any notion of a social relationship that is intrinsic to relational goods is fatally damaged by the transformation of these goods into commercial commodities.

Recipients of social care want to be treated as people, as ends in themselves, not merely as a means for others to make profit, nor as a “client” of a state or professional bureaucracy. In the provision of relational goods, it is not only important *what* care is provided. Equally important is the *way* care is provided.

To put it in concrete terms, it is not enough that a doctor treats her patients competently. This is a minimum expectation. It is also important that she treats her patients *humanely* (V. Zamagni).

How then, do social co-ops address these questions, and what are the wider implications for civil society on the issue of social care and the role of the state?

The Social Co-op Alternative

One effect of social co-ops in Italy is a measurable improvement in the range and quality of services. The Italian experience has also shown that co-operative models are more cost effective than state alternatives.

In a recent study of elderly care in Emilia Romagna, it was shown that social co-ops provided a superior service at well below the cost of state programs. This can be traced to a number of factors: more flexible working conditions, the involvement of voluntary labour, and a higher commitment among workers resulting in higher efficiencies of service delivery. In addition, the services were freed of artificial costs associated with the maintenance of a state bureaucracy.

Over 40% of social co-operatives are worker co-ops whose members are professionals. They vary in size from 10 or 12 individuals to over 500 as in the case of CADIAI, Italy’s largest social co-op which provides a range of services in the health services and senior care field. The remainder also involve other stakeholders such as volunteers, users and families as members.

In almost all cases, social co-ops provide their services under contract to municipal authorities or other public bodies. And although these contracts must be won through an open bidding process, services such as health, education, and senior care are restricted to organizations that are either non-profit associations or co-operatives. In this sense, social services remain a protected market.

But the success and phenomenal growth of social co-ops as an alternative to state delivery systems has spurred thinking toward the creation of a true *social market* in Italy. By a social market, we mean the production and exchange of goods and services which promote *social* objectives. In such a market, many services would be provided by organizations operating within the social economy. In these cases, the state would retain a funding and regulatory role. For other services, like public education and transportation, the state would remain the primary provider.

Nevertheless, an important shift is taking place through the recognition that while the state is still responsible for *providing* social services, it does not need to *produce* these services. Indeed, the inherent nature of government as set against the unique and changing needs of citizens argues against such a role.

A social market presupposes three conditions:

- a) the production and consumption of relational goods on the basis of the principle of reciprocity that characterize the operations of civil society and the social economy.
- b) freedom of choice on the part of citizens with respect to where these services are to be procured.
- c) The capacity of *all* citizens to participate in the determination of the goals and objectives to be reached.

A key element with respect to the creation of a true social market is the *democratization* of social services.

In both state and for profit systems, individuals have little or no power to determine the nature of the services they receive. This is especially so in a “private” market where the need for services exceeds the available supply. The development of a social market in which citizens share control over the delivery of social care would not only increase the supply of services. It would expand the range and responsiveness of services being offered.

It is in this respect that co-operatives provide a unique advantage with respect to the design and delivery of social care.

For those who advocate 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. What are needed are modes of social care that embody the attributes of reciprocity, accessibility, accountability, and efficiency if alternative models of care are to be viable.

This point has been made by many groups who are deeply involved in the provision of care to people and their communities. It has been a key element in the promotion of the concept of “blended care” which seeks to reform the health system by incorporating the principles of prevention, community involvement, and user control into the provision of primary health care.⁶

The co-operative model has provided a highly effective way of organizing and mobilizing these principles within civil society. But it has done so by linking the entrepreneurial element of ownership rights as found in traditional co-ops to the broader purposes of social care.

Social co-ops, like all co-operatives, are designed to convey control rights to stakeholders and members. In this sense, they are distinct from other non-profits which are defined essentially by the constraint on distribution of profits. 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, to being an active protagonist in the design and delivery of the care. 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.

It is no accident that the caregivers and families of people with disabilities pioneered the social co-op model. It was here that the inadequacies of state models were most keenly felt.

It is also in the provision of services to vulnerable people that the social co-op model has taken root in Canada, particularly in Quebec. There are over 20 “solidarity co-operatives” operating in Quebec that have adopted the multi-stakeholder structure to provide a growing portion the home care market in that province, in partnership with the province’s 160 community health centers.

However, in Canada the articulation of civil society’s role in the production of social services is still very unformed. The debate on this issue is just beginning. And, there are understandable fears concerning the manner in which an increased role by civil society might reinforce the trend toward more privatized care.

But the same pressures of service quality and service cost which drove the Italian system to take seriously civil society’s role continue to raise the issue of progressive alternatives in this country. Equally pressing is the pervasive influence of neo liberal free market ideology on the operations of the public sector.

⁶ “Blended Care”, Discussion Paper by the BC Nurses’ Union, Hospital Employees’ Union, BC Government and Service Employees’ Union, October 1999.

The BC Context

The continuing debate over the proper role of government in the provision of such services as child protection, services to the disabled, health care, and social assistance, invites the exploration of alternatives that move beyond the fixed positions of Left and Right on these questions. There is much in the Emilian experience of social co-operatives that can break the current impasse on public versus private care.

The traditional position of the Left on this question has focused on the need to protect the state's pre-eminent role in both the funding and production of social services. But this form of neo-welfarism as it has come to be known, has had little to say about the appropriateness of conventional state systems with respect to the treatment of social care recipients, the relational qualities inherent in social care, the additional cost of sustaining government delivery systems, and the accountability of care systems to those who use them.

The role of civil society has been perceived primarily as a source of advocacy to defend against abuses of authority of one type or another. There has been little articulation of how civil society might *expand* its role beyond a defensive political posture.

The position of the Right in this debate is well known and has largely defined the terms of the public discourse. The Right proposes a view that makes no distinction between social and commercial goods, and applies corporatist models of managerial control and private market measures of economic efficiency. There is likewise, no recognition of provider accountability beyond the choice that "consumers" as clients would exercise in a free market setting.

Both these views are inadequate to respond to the issues that must be addressed if social care is to reflect the real needs and expectations of contemporary citizens.

In civil society, the time is long overdue for a radical re-appraisal of public and social services from the perspective of citizen control and the public interest. One approach is the establishment of a true social market that places the institutions of civil society, most importantly user controlled co-operatives, at the forefront of social service delivery.

For example, the development of a social market in the provision of services to the disabled would allow persons with disabilities to form co-operatives to provide themselves with services they now receive from the state as dependents. Similarly, professional caregivers would be free to develop co-operatives to provide such services to this group. In both cases, government would provide funding directly to citizens for the purchase of these services either individually or through co-operatives that they control.

This is an area where British Columbia is breaking new ground through the transfer of control of disability funding programs directly to the families and individuals that receive disability benefits. It is the culmination of a battle that people with disabilities have been fighting for a decade.

Another area of great need and certain growth is the provision of home care and services to the elderly. The recovery and potential re-investment of savings in senior care has already been documented in the use of social co-operatives in Italy. In Canada, the rapid growth of home care co-ops in Quebec speaks both to the viability of these services and to the unmet needs of this demographic in our society.

Conclusion

There is no doubt that there are real risks in the changes that are being implemented by the reform of state delivery systems.

But it remains true that state delivery systems, however well meaning, are often inadequate to the task of providing humane care. The push for system change and greater control on the part of those most affected is clear evidence of this. The real question is, what are the civil

institutions that must be built if progressive alternatives are to be found to state delivered systems on the one hand, and privatization on the other?

Civil society has always been the wellspring of social care. Many government programs that are now taken for granted were modeled on the work of organizations in civil society that provided for health care, elder care, care for those with disabilities, and a host of other services. Canada's Medicare system was modeled on the mutual aid societies and community health co-operatives that were pioneered in Saskatchewan in the forties, fifties, and sixties.

The emergence of publicly funded, universally accessible state systems was a necessary evolution in the political and organizational capacity of Canadian society to maximize the benefits of collective responsibility for social care.

The argument for promoting a renewed role for civil society in the production of social services does not mean the abandonment of the fundamental principle of collective responsibility for these services. Nor does it mean the abrogation of state responsibility in favour of market solutions. Public funds would still flow to these services.

What we recognize is that civil society is the repository of those values and social relations that are best suited to the provision of care in a manner that is humane (i.e. decent in the sense of A. Margalit), responsive, and founded on those principles of reciprocity and mutuality that are the hallmarks of caring relationships. What is lacking is the development of civil society institutions that are capable of applying these values on a scale, and in the context, of a modern mixed economy.

The growth and formal sanction of user-controlled institutions such as co-operatives, democratizes social services and introduces the crucial element of accountability into social care. Secondly, the co-op form can be used to extend greater control over the design and delivery of care to professional caregivers. The blend of these models in multi-stakeholder systems opens the way to a true collaboration between providers, recipients, and even public authorities in a manner not possible with the status quo.

In many ways, the struggles that have gripped civil society in the formulation of an adequate response to the Canadian situation are part of a necessary maturation process that in the end will give birth to new forms of social care.

The spotlight that has been thrown on the role of civil society with respect to social care is not one that was sought. It emerged as a consequence of the changes that were thrust upon the state as a result of financial, organizational, and ideological pressures. To date, the posture of the leadership that has arisen in civil society to respond to these changes has been primarily defensive.

However, the experience of the social co-operative movement in Italy has shown that it is possible, even necessary, to move beyond the conventional framework of this debate to advance a new vision of social care that places in better balance the values of civil society with the resources and redistributive powers of the state.