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Voluntarism, defensive localism and spaces of resistance to health care restructuring

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ABSTRACT

This paper examines the evolving role of volunteers and the voluntary sector in shaping community responses to structural change in health care systems. It contributes to the emerging understanding of the different forms voluntarism can take within and among places, including as a space of resistance to contemporary restructuring initiatives such as regionalization. Within the geographies of voluntarism literature, however, little attention has been directed towards interrogating the local dynamics of such voluntarism, especially as it is reflected in public discourse. We address this deficiency through a media-based case study of public reaction to the recent implementation of Ontario's Local Health Integration Networks (a type of regional health authority). Specifically, we examine a decade of newspaper coverage in a mid-size Canadian city region to document and characterize how the activities of volunteers and voluntary sector organizations in the community are portrayed in light of the structural imperatives to integrate health care services and regionalize health care governance. The media findings reveal a suite of public concerns and related activities, with the voluntary sector called upon in various ways to defend the autonomy of the community against the perceived threats to local services, employment and vulnerable populations. We interpret the evident complexity of voluntary sector resistance as a form of 'defensive localism' and discuss implications for developing informed policy on health care restructuring and for advancing knowledge on the local geographies of voluntarism.

1. Introduction

Within the growing and diverse literature on geographies of voluntarism, there has been an increasing interest in the theorization and empirical validation of the evolving role of the voluntary sector and volunteers in an era of structural and societal change (Fyfe and Milligan, 2003; Milligan, 2007).[1] From Wolch's (1990) pioneering work on the shadow state, through Milligan and Conradson's (2006) landmark anthology on landscapes of voluntarism, to the special issue of *Health & Place* edited by Skinner and Power (2011), geographers have sought to situate the role of voluntary organizations and volunteers within processes and outcomes of, and responses to, structural change, especially at the local level. Studies within health geography, for instance, have investigated the ways in which voluntary sector activities have shaped community responses to processes as diverse as de-institutionalization in the 1980s, privatization of health care services in the 1990s, and regionalization of health system governance in the early 2000s (Skinner and Power, 2011). Parallel interests in the evolving role of voluntarism can be found in the broader geographical and increasingly interdisciplinary literature on the social and spatial dynamics of restructuring in urban areas across the global North (e.g., Cloke et al., 2007; Joassart-Marcelli et al., 2011; Woolvin and Hardill, 2013).

Regardless of specific focus, within studies of voluntarism attention increasingly has been directed away from understanding the voluntary sector as a target of government devolution, divestment and downloading agendas, towards its fuller theorization as a complex and multi-facetted space of resistance for individuals and communities coping with the challenges and opportunities created

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[1] 'Voluntarism' refers to the activities of voluntary sector organizations and volunteers in support of health and social welfare, with the 'voluntary sector' (and the generally synonymous 'non-profit sector', 'social economy' and 'third sector') comprising a range of organizations and groups that are not part of the state (non-governmental), are not profit driven (non-profit), and involve some degree of participation from individuals who perform activities without pay as an act of citizenships and/or philanthropy (volunteers).

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by systematic and often rapid change (Skinner and Power, in press). While attention increasingly has been directed towards interrogating the socio-spatial dynamics of 'voluntarism as resistance' (see contributions to the collections edited by Milligan and Conradson (2006) and Skinner and Power (2011)), very little has been directed to understanding how voluntarism is reflected in public debates about local responses to change (Joseph and Skinner, 2012). This gap in knowledge is of particular concern because, as observed by Skinner et al. (2013), in the absence of appropriately-structured empirical research, there is a risk of over-theorizing the potential of voluntarism within the academic literature on the one hand and of over-estimating (or even romanticizing) the role of volunteers and voluntary organizations within public discourse on the other.

In this paper, we seek to supplement the limited stock of case studies probing voluntarism as a space of resistance to structural change by examining the role of the voluntary sector in shaping local responses to the re-organization of health care services into region-based health authorities in Ontario, Canada. Specifically, we present a media-based case study of the public discourse on the implementation of such changes in a mid-size Canadian city region and pursue three interrelated objectives. First, we document and characterize how the activities of volunteers and voluntary sector organizations are portrayed in light of the structural imperatives to integrate health care services and regionalize health system governance. Second, we ground our observations in evolving conceptual debates on voluntarism as a space of resistance by interpreting voluntary sector responses as a form of 'defensive localism' (Winter, 2003) in which voluntarism is invoked publicly as a means of defending the local autonomy of the community against perceived threats to local services, employment and vulnerable populations. Third, we further problematize the space of resistance concept by considering the implications of the attendant subjugation of voluntarism as part of the valorization of 'local' within both policy and public discourses (Woolvin and Hardill, 2013). Our analytical emphasis is on uncovering insights that advance understanding of the geographies of voluntarism and shed light on the importance of geographical approaches within interdisciplinary health studies as a means of contributing to the development of informed policy on health care restructuring. We begin by situating our case study with reference to key ideas on the evolving geographies of health care, voluntarism and resistance.

2. Geographies of health care, voluntarism and resistance

Geographers have long been interested in the spatial dimensions of health care systems (e.g., see Shannon and Dever, 1974; Joseph and Phillips, 1984; Gesler and Ricketts, 1992; Mohan, 2002). Situated broadly within health services research (Barnett and Copeland, 2010), approaches in medical and health geography range from regional-descriptive accounts and comparative analyses of health care systems around the world, through political economy, feminist and post-structural critiques of health care inequalities, to place-based interrogations of the implications of structural changes such as de-institutionalization, privatization and regionalization (Kearns and Moon, 2002; Kearns and Collins, 2010). The latter emphasis on place has remained particularly relevant as local communities are almost always positioned as key players in the 'changing geography of care' (Milligan and Power, 2010), and it is towards a better understanding of these local dynamics of voluntarism that our research is directed. We view our endeavor as part of the broader contribution that the geographies of voluntarism literature has made to interdisciplinary research on health and social welfare systems and policy (Milligan, 2007), particularly in advancing interdisciplinary applications of place-based approaches to the study of processes, outcomes and responses to change in health care systems (e.g., Williams et al., 2016).

2.1. Changing health care systems

Over the last three decades, health care systems across countries of the global North have been subject to successive rounds of restructuring.[2] Although a broad shift from institutional to community-based care had been under way since the mid-twentieth century, concerns over rising deficits and the escalating costs of welfare state service provision led to the introduction in many jurisdictions of a series of general and service-specific measures to reduce state responsibilities for the provision (and funding) of health care (Milligan and Power, 2010). While the form of constituent policies and institutional actions invariably exhibited a degree of historical and geographical specificity (e.g., see international contributions to Scarpaci, 1989; and Knight and Joseph, 1999), across jurisdictions national and sub-national governments generally deployed a mixture of market-based approaches while simultaneously encouraging, or even co-opting, voluntary and informal care providers in as a means of controlling costs (Milligan and Power, 2010).

Publicly-funded health care systems like those in Canada, New Zealand and the UK that aspire to reduce inequalities in access to services are of particular analytical significance to researchers interested in understanding the processes and outcomes of restructuring. At the sub-national (provincial) level in Canada,[3] where responsibility for health care rests, imperatives for restructuring have been expressed in a series of ideologically-driven initiatives (Ostry, 2006). In Ontario, the jurisdiction in which our case study is situated, successive proposals were dominated, in turn, by ideas of *co-ordination*, *restructuring* and *integration* (Baranek et al., 2004). Similar to other national and sub-national jurisdictions across the global North, the strategies employed in Ontario appear to be synonymous with widespread government efforts to, at once, improve the delivery of health and social welfare at the community level while also reducing the role of the state in the provision of public services (Pinch, 1997).

To illustrate, in the late 1980s, the Liberal (centrist) provincial government of the time initiated a series of policy documents and pilot projects aimed at better *co-ordinating* what was widely seen as a piecemeal community health care landscape (Cloutier-Fisher and Joseph, 2000). Particular attention was directed to long-term care. Strategies for achieving greater coordination of the latter included a one-stop access system of case management, an Integrated Homemaker Program, and a service hub organization known as the Service Access Organization (Williams, 1996). Additionally, 14 regional Ministry of Health and Long-term Care offices were established as a means of improving service co-ordination at a regional level. These co-ordination strategies were framed politically by recognition of the increasing need for services to support the province's aging population and related projections of the growing strain on fiscal resources (Baranek et al., 2004).

When a Progressive Conservative government came into power in 1995, they moved quickly to implement their own (re-named) service hub, the Community Care Access Centre, which would not only coordinate service delivery, but also *restructure* the service

[2] 'Restructuring' refers to the application of regulatory principles to public sector institutions such as health care services and involves orchestrated processes of structural change aimed at reducing overall government commitments to the welfare state.

[3] Canada has ten provincial and three territorial health care systems, all of which administer their own health care services (Government of Canada, 1984), including regional health authorities ranging in size from a single health region in Nunavut (pop. 32,000) to 18 health regions in Quebec (pop. 7.9 million).