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**Chapter: “Voluntary Sector and Urban Health Systems.”**

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**Abstract**

Beyond the role of the state and private sector, the task of responding to increasingly complex challenges in delivering urban health care in the early 21<sup>st</sup> century is being met by the voluntary sector. This chapter outlines some of the key critical points of debate concerning how the voluntary sector has moved into this focal position. The first half of the chapter traces how the role of the voluntary sector has followed a complex trajectory since being ‘rediscovered’ by the state in the 1970s, defined by three phases: as panacea, paradox and precarity. The second part of this chapter explores how the voluntary sector is both ‘in’ and ‘of’ cities: voluntary organisations concentrate there, but they have also cultivated greater cultural proximity and solidarity with urban residents’ local values. Yet, relying on a sector that by default is more de-centralised and organic becomes a challenge in contexts where urban space is marked by various pressures around precarity of health services.

**Introduction**

Understanding how urban health systems are shaped requires a focus beyond merely the role of the state. In fact, as explored in the last few chapters, the role of the state has proven to be quite a variable player in the provision of welfare. Indeed, in some nations the private sector has become more of a key player in urban health systems (e.g. Health Maintenance Organisations in the United States). Alongside the state and private sectors, many of the actors and institutions involved in promoting good health and preventing the poor health of individuals, particularly at the local neighbourhood level within cities (e.g. managing stress, loneliness, and isolation through wellbeing initiatives) are situated within the voluntary sector. This sector is comprised of a multitude of different organisations, including international and national charities and support providers, local care groups, and community support networks. Their involvement is most readily seen in the provision of community care

for people with mental health issues (DeVerteuil 2015), disabilities (Power and Bartlett 2015), and support needs in older age (Milligan and Wiles 2010). Fundamentally, the health ‘system’ should be understood as more than solely ‘health services’: it can include urban transport, community networks, public amenities, and educational services. Indeed, any community-led resource that helps people’s health and wellbeing can be included. Taken together, the actions of the voluntary sector and volunteers, both formal and informal, are rooted in the broader philosophy of voluntarism—that is, non-coerced action by civil society, usually for public benefit, outside the constraints of the state (Brandsen et al 2005). When seen in this light, the voluntary sector is a significant player in urban health, through a myriad of different initiatives, for example, community transport schemes, urban farms, and lifelong learning groups (e.g. Men’s Sheds).

Rather than solely offer a review of literature, the purpose of this chapter is to outline some of the key critical points of debate concerning how the voluntary sector is evolving and responding to the increasingly complex challenges in delivering urban health care in the early 21<sup>st</sup> century, drawing on pertinent literature where relevant. It is a chapter of two halves. The first half aims to trace how the role of the voluntary sector has followed a complex trajectory in recent times, which we argue is defined by three phases: as panacea, paradox and precarity, as justified below (Skinner 2015). The second part of this chapter explores how the voluntary sector is both ‘in’ and ‘of’ cities: voluntary organisations concentrate there, but they also must respond to greater and more complex demands counter-posed by greater density, solidarity and proximity (DeVerteuil 2015).

Following Skinner (2015), the three-phase characterization of panacea, paradox and precarity that we develop in the chapter is employed to tease out the complex and constantly evolving nature of the sector and to better understand the challenging context that it currently operates in. It takes as its starting point the period from the late 1970s, when the voluntary sector was ‘re-discovered’ by governments as a potential central player in welfare provision in response to international fiscal crises; it was viewed by policy makers and researchers as a panacea for ameliorating the effects of the crises on statutory health and social care provision. With the closer working relationship with government, voluntary organisations faced new tensions, in terms of how it managed increased bureaucratization, greater expectations over its service delivery and coverage, and control over its client groups. Given these tensions, the sector began to be considered as a *paradox* by scholars who identified the uneven outcomes from an increasing reliance on voluntary organisations and the discretionary co-option by the state

(e.g. Skinner 2008). More recently, after decades of neoliberalism and shrinking state funding, the sector is arguably now being viewed as a source of *precarity* by urban geographers and others: the risks of unsustainable volunteer-based initiatives for different populations are beginning to become more evident, and without the state as an enabler through grant funding, the sector is itself becoming more precarious and volatile (Mohan and Bulloch 2012; Bode 2006; Skinner 2014).

Ultimately, the way this broad context is playing out is having a significant impact on how the voluntary sector operates *in* cities, and on how it continues to be *of* cities. As stated, the purpose of the second half of the chapter is to better understand how the broader level changes outlined in the first half can affect these two positions.

A focus on the underlying challenges underpinning the role of the voluntary sector vis-à-vis the state is timely, given the reliance on this sector to ‘mop up’ many of the casualties of 21<sup>st</sup> century capitalism and post-welfarism. Moreover, a focus on the urban geographies of voluntarism can reveal the crucial difference ‘place’ makes to understanding voluntary activity in the context of urban health, care and wellbeing (Skinner and Power 2011).

### **The Voluntary Sector and Urban Health Systems: from panacea, to paradox, to precarity**

The voluntary sector has always existed as a space outside the state. Indeed, voluntary sector organisations often led the way in being a *precursor* (a fourth ‘p’) to state efforts, by first establishing support services for many citizens (beyond what was being provided in state provincial asylums and jails). In the pre-welfare state period (predating 1948), voluntary care evolved out of charity, philanthropy, advocacy movements, and religious aid. Large philanthropies, such as Foundation Hospitals and Barnardos in the UK, were seeking to respond to the growing health impacts of large-scale urban population growth during the industrialization in cities and the associated growth of inequalities in wealth and access to housing (Mohan and Gorsky 2001). This period also saw quite a lot of change in how the state and voluntary sector combined to provide healthcare. For a more detailed history of this period, see Hilton and McKay (2011). Following the post-war settlement, similar governance regimes throughout Western Europe emerged materializing in an ‘organized welfare mix’ (Bode 2006). As we saw in the last chapter, welfare provision was characterised as being relatively universal and comprehensive with the central government taking more significant

roles, across Europe and North America. The policy of viewing voluntarism as the ‘extension ladder’ was promoted in many countries, with the idea that the voluntary sector would provide specialist services or add-ons to those provided publicly. Even in strongly Catholic countries such as Spain, Portugal, and Ireland, where state intervention in the family was opposed by the Church, state provision of services gradually extended into many areas of public life from the late 1950s.

For the purposes of our chapter, we fast-forward to the period following the post-war welfare settlement, when many Fordist, universal, comprehensive welfare states began to come under greater scrutiny, and a deliberate and decisive effort was made to redefine and carve out the boundaries between the state and the voluntary sector. Our purpose here is to disentangle the more contemporary strands of voluntary sector involvement since the initial rise and subsequent decline in welfare provision, as outlined in the previous chapter. Since the 1970s, the voluntary sector began to occupy a relative ‘heyday’ in contrast to the subsidiary role that it occupied during the earlier welfare consensus with a more complex contractual relationship, just as cities themselves began to face more complex health demands.

Esping-Anderson’s (1990) work on the different ‘regimes of welfare’ (liberal, corporatist and social democratic) and Salamon and Anheier’s seminal work on national voluntary sector typologies (1994; 1997; 1999) is helpful in giving us the initial building blocks to examine recognisable traits associated with different welfare state configurations. Their work comes with its own health warning though, in that significant variations do exist within such regimes, and there is no pure fixed form. From here, we can then draw out the implications for the voluntary sector at the local, city level.

### *Panacea*

The supplementary role that the voluntary sector occupied within the welfare state would change from the late 1970s with a growing neoliberal political discourse about a mistrust in what government saw as paternalistic public services from the post-war era (Gamble, 1974; 1981; 1988). This was characterised most visibly by the Winter of discontent in British politics which many see as marking the end of the United Kingdom's post-war settlement. Once ‘community care’ got policy attention from the 1970s, state funding of the voluntary (and private) sector and delivery of social work and ancillary services grew. It became a universal policy solution in some nations, as evidenced in the Third Way in the United Kingdom. Family members also became ‘recognised’ for their potential to care for people

(Land and Rose 1985). To an extent, family caregivers could also be conceived as occupying this sector, however given the individual locus within the family, and the fact that many people do not have a choice about caregiving for relatives, they are ordinarily thought of as occupying the ‘informal sector’.

One could argue that the voluntary sector from this time became re-vitalised. It was heralded as a panacea, by both government and researchers with an increasing focus on the ‘sharing economy’ and ‘active citizenship’ (e.g. Amin et al 2002; Kearns 1992). In countries deemed to have ‘liberal’ welfare regimes, such as United States, Canada, and the United Kingdom, the voluntary sector from the late 1970s began to (re-)occupy a larger role in urban health systems. It is here, that collective consumption institutions became most under siege and voluntary organisations began to be relied upon more openly as ‘non-profits for hire’, as welfare policy shifted toward privatization and contracting out (Smith and Lipsky 1993). Citizens in such nations witnessed a gradual ‘entropy of the state’, which has continued and accelerated to this day (Streek 2016). This transition has been hugely complex, arguably driven by multiple forces such as global capitalism and financialization of public sector services as well as neoliberal/neoconservative ideology.

The Salvation Army in the United States serves as an example of a ‘big player’ within this landscape as it became responsible for significant social services, with 17 percent of its operating budget coming from government funding in 1980 (Salamon 1995) – a rate broadly consistent with funding levels in the early 2000s (Mink and O’Connor 2004). During the 1980s, the provision of inner-city food banks and soup kitchens accelerated dramatically in response to growing demand, as the US experienced the deepest recession since the Great Depression. This was intensified by decreased federal spending on welfare benefits, resulting in a significant increase in people being impoverished within US cities. The homeless emerged as a new national concern. In response, the religious charity increased the scope of their services including more inner-city drop in services and ongoing support for homeless people, activities to combat isolation amongst older people, and emergency assistance and budgeting advice for people in poverty. It is now the fourth largest charity in the United States, dropping from the second largest in 2016, ranking behind *Feeding America*, another organization that manages food banks (but through individual and corporate donations) in cities around the country (Barrett, 2016).

In Britain, the National Health Service (NHS) represents an anomaly to its otherwise residual market-led liberal regime model, as it continues to be a centrally funded, government provided health service, although, creeping privatisation is evident within recent reform efforts (Peedell 2011). Despite the differences between Britain and the US, they share a basic notion that an organisational space exists distinct from the state and the market. The terms ‘not-for-profit organisations’ or the ‘third sector’ were increasingly used to characterise those bodies that became involved primarily in the areas of urban service delivery. This shift reflects the neo-liberal political tendency to withdraw from provision on one hand and to maintain control over its subsidiaries on the other hand.

In countries deemed ‘corporatist’, such as those in continental Europe (e.g. Germany, France, Belgium), while a considerable ‘non-profit’ sector exists, the concept of an organisational space distinct from the state and the market was far less clear. Here, people continued to derive state benefits through social insurance, with relatively more generous welfare services. Even after the growth of national social spending had largely subsided in Germany, social spending by the municipalities that managed services for their respective cities as share in their budgets still almost doubled from 11.8% in 1980 to 21.7% in 1996 (Alcock and Craig 2001). The right to form private non-profit organisations was more tightly defined by law that mandated public/private partnerships at the local level: consequently, the sector was typically defined as the ‘public-serving non-profit sector’ (in Germany, as ‘free welfare organisations’). It is worth remembering that East Germany continued to have a centrally-planned socialist economy until 1991, at the time when other nations’ welfare states were already beginning privatization. For cities like East Berlin and Leipzig, it became evident that economic growth was grinding to a near halt though by the end of the 1980s, despite earlier success. Despite not having a clear organisational space, according to Anshieher and Salamon’s earlier seminal work (1994; 1997; 1999), the non-profit sector was nonetheless a major employer in Germany and attracted a considerable amount of volunteer effort: indeed, more than one-fifth of the German population reported contributing their time to non-profit organisations. Of all the types of non-profit activity, the one that accounted for the largest share of non-profit employment in Germany was social services. The principle of subsidiarity evident in Anshieher and Salamon’s work, remains ever relevant in shaping this activity (Bönker and Wollmann 2000), where priority is assigned to private, non-profit provision over public provision of welfare and social services, albeit with public financial support being guaranteed at the same time.

In countries deemed ‘Social democratic’, such as the Scandinavian countries Finland and Sweden, the sector continued to take a more supplementary/ancillary role in urban health and social services. Here, the culture of government-provided health and social care remained consistent until much later than other nations. There was limited support from philanthropy and the public sector for voluntary organisations within Scandinavian cities. The dominant source of income of non-profit organisations in Finland was fees and charges for the services that these organisations provided, as well as membership dues. Although social welfare services absorbed nearly two-thirds of paid non-profit employment in Finland, their combined share was not as significant as elsewhere in Western Europe where non-profit organisations became much more engaged in service delivery (Salamon and Anheier 1997).

Strong currents of this favouring of the sector over the state still remain, as much evidence is showing that voluntary organisations continue to be increasingly relied upon. With growing global and within-country inequality (Stockhamer 2013), a new global order of competition between high-income nations is leading to the hollowing out of jobs (Ong 2006) and an increasing pessimism and anti-politics regarding the role of state institutions in people’s lives (Clarke et al 2016; James 2014). The role of the state is arguably complicit in cultivating this disfavouring of its role in urban health systems, as it itself has sought to radically reform (that is, withdraw from) social welfare provision, and has become less visible a stakeholder as a result. That said, while it withdraws from direct provision of welfare, its control over the ‘market’ of voluntary and private sector provision arguably remains.

### *Paradox*

The above shift no doubt rejuvenated the voluntary sector in many ways, and made it a more significant player in dealing with the casualties of the international fiscal crisis in inner-city areas. For a full appraisal of the breadth of the sector in this context, see Skinner and Power (2011). Some examples of organisations providing urban health services include Non-Governmental Organisations (largely in the Global South, such as Action Aid), global philanthropy organisations (e.g. Bill and Melinda Gates Foundation), inter-national charities providing support (e.g. Salvation Army; Alzheimer’s Society), as well as smaller community groups operating solely at the neighbourhood scale within cities (e.g. urban farms and Men’s Sheds). In terms of their role in health, as stated, the voluntary sector now includes health promotion efforts as well as poor health prevention initiatives (e.g. managing stress,

loneliness, isolation), infectious disease treatments (in Global South cities), mental health, disability, frailty in old age, maternal health, and chronic illness for a variety of different populations.

However, the positive outcome of this expanded role has since been judged less clear-cut. In the 1980s and 1990s, a greater degree of formalized and interconnected partnerships between the state and voluntary sector evolved (Osbourne, 1998). This was witnessed not only in the liberal nations mentioned above, but in other countries where liberal models of welfare also had begun to evolve, as collective consumption institutions also came under greater siege in nations such as Ireland, Greece, the Netherlands, as well as South American countries such as Chile. Welfare and health care provision in all these nations have since become more market-led and residual since Esping-Anderson's (1990) work. Wolch's (1990) coining of the term 'shadow state' provided the most clearly articulated account of this paradox, highlighting the way that the voluntary sector was becoming co-opted by the state to become a quasi-public provider of services. In effect, the international voluntary sector 'contract' began to change. In many nations identified thus far, the state no longer considered itself in a position to fully provide social welfare within its cities and needed a 'helping hand' from elsewhere. This entailed a 'shift from government to governance . . . on all scales' (Jessop 2002: 35). Urban services began to be administered via 'quasi-market governance' (Bönker and Wollmann 2000; Brandsen 2004; Le Grand 2003) involving greater roles for voluntary and private sector organisations, although significant variation existed, with some cities being governed by left-leaning authorities, such as Newcastle in England for example.

Scholars (Morrison 2000) have traced how those involved in voluntary work have become more routinely categorized, and their work more subject to training. More rigorous auditing and employment protocols have been enforced by the state, as well as punitive controls when non-profit organizations do not meet the requirements necessary (e.g. the 'Kids Company' scandal in Britain, where a large children's charity was dissolved because of financial misconduct). Wolch's (1990) earlier work on the shadow state, as noted, has helped scholars maintain a critical awareness of the increasingly quasi-public nature of the voluntary sector as the reach and depth of neoliberalism (or neoconservatism in the United States) has steadily increased in the 21<sup>st</sup> Century. Even in some countries where the state continues to have a significant role in direct health care provision such as the United Kingdom, there are reports of a slow creep of privatisation and the re-routing of support provision to voluntary and private organisations (e.g. Peedell 2011).



Another significant contribution that urban geographers have made to our understanding of the paradox of voluntary sector revival, has been research identifying the fragmented, decentralized, and ad hoc provision of support that has unfolded within and across cities, as a result of being reliant on a piecemeal voluntary sector (Mohan and Bulloch 2012). This is a theme we examine further in the second part of the chapter. As a result, scholars have felt that public welfare retrenchment has eroded the centralist and universalist foundations of support services. Ong's (2006) work in Singapore and Silicon Valley has shown that civil rights protections – rights, entitlements, the state – are being increasingly disarticulated and replaced with ambiguity, discretion and contingency in provision.

With this brief historical perspective, it is clear that the voluntary sector has changed and evolved significantly over time. As indicated in the introduction, given the changing mix in health and social care provision, many scholars began to characterize the expanding role of voluntarism, and the professionalization of the sector as a paradox. It had evolved from providing a complementary or supplementary role to being seen as an alternative and, in some cases, a subservient (or co-opted) provider of health and community care services (Skinner and Rosenberg 2005).

### *Precarity*

Since 2008, following another period of global fiscal crises, a more stringent and distilled neoliberal-inspired position of austerity has been invoked. The political landscape has since seen a deeper, more wholesale rolling back of the welfare state and a starker 'brokerage' of new deals with voluntary organizations in the Global North (Power and Hall 2017). In some nations, such as Greece and Ireland, the governments have been largely coerced into more residual state provision, as a result of pressure from European Union partners and the World Bank. Featherstone et al. (2012) has characterized this brokerage in the context of austerity as 'austerity localism', involving a further re-positioning of the voluntary sector and community as central players needed in the restructuring of healthcare and welfare systems.

As austerity has intensified, the concerns identified by scholars above have been largely confirmed, as the current reliance on the sector has led to a source of *precarity*, for the people reliant on it, and for the very sector itself (Horton 2016). The 'welfare mix' is now more volatile, sporadic and fragmented, with private sector investors even winning social work contracts from local authorities, a former staple of public provision (e.g. Virgin winning a

social work contract in Birmingham). Within academic scholarship, voluntary organisations, according to Bode (2006) are conceived of either as a mere appendage of a modernized public administration – an understanding which widely denies their particular role in the provision of social welfare – or as marketized agencies becoming a mere business partner of ‘managerial states’, as first claimed by Clarke and Newman (1997) – a perspective which may justify seeing their link to civil society becoming redundant.

In truth, the sector is contradictory and complex, being comprised of a myriad of different size organisations operating at different scales, ranging from large inter-national organisations with a network of branches across cities, to local borough-level community groups, operating within a single neighbourhood. At each scale, the financial challenges of operating in increasingly residual welfare regimes in the Global North exist which contribute to the precarity of the sector.

Returning to Esping-Anderson’s work on regimes of welfare, a general trend that has occurred has been the roll back of the state formerly in liberal countries becoming more evident in corporatist and social democratic countries. Wolch’s (1990) earlier pivotal work on the shadow state is becoming more evident, as traditional civil rights protections and entitlements are being increasingly disarticulated and replaced with ambiguity, discretion and contingency in provision (Ong, 2006). Welfare is becoming increasingly more disorganised and sporadic (Bode, 2006). Esping-Anderson’s models give us some indication of different voluntary sector positionings in the Global North and a reference point for understanding the more recent precarious positionings that have unfolded. However, this work is obviously limited in that it fails to capture how precarity is felt and managed differently by the voluntary sector organisations delivering urban health care across the Global South. This gap is symptomatic of a broader dearth of work in urban geography on the Global South (with some exceptions, see Miller 2013; Skinner and Power 2011). Cities in low-income countries in the Global South, such as Africa, often share complex challenges. As the following section shows in more detail, there are certain health risks associated with poverty and infectious diseases, such as malaria. The state is also often not in a position to fund health care delivery at a level comparable to high-income social democratic countries. Cities in the Global South also have some of the most striking inequalities in the world, with a small urban middle class. Where the development of health insurance is relatively advanced, such as in Latin America, less than 20% of the urban poor have access to some sort of insurance (Fay 2005). Financial obstacles are a major challenge for urban health development. Common across low-income

countries is their relatively low levels of government social welfare spending. A typical African country spends less than US \$5 per person per year on public sector health (Sachs 2004). Non-Governmental Organisations therefore play a significant role in urban health care and tend to dominate debates about health provision in the Global South. However, Anheimer and Salamon's (1998) authoritative book which examined the non-profit sector across Brazil, Egypt, Ghana, India and Thailand, found that focusing exclusively on NGOs gives a distorted picture of the true scale and character of the non-profit sector in these countries. They revealed entities as diverse as village associations, grass-roots development organisations, agricultural extension services, self-help cooperatives, religiously affiliated schools and hospitals, human rights organisations, and business and professional associations, to name just a few. However, it is also worth noting that in some Global South nations such as Egypt and Thailand, strong authoritarian state control and a mistrust of voluntary organisations and democratic involvement also figures prominently (Anheier and Salamon 1998).

Taken as a whole, this body of work provides an indication of some broad discernible trends in the operationalisation of voluntarism within urban health across different international contexts. It is possible to discern that global pressures have created a greater reliance on the sector, as different national political principles converge towards lesser state provision, thus changing the balance from a sector being paid through individual fees or government contracts. The section that follows will examine how this sector has been shaped by different welfare regimes at the local urban scale, and how it has more recently responded to the changing landscape of state provision and the wider challenges of operating alongside an 'austere' state. It draws on different case-studies of voluntary organisations *in* and *of* cities to examine the more complex everyday challenges facing the sector, and their practices for seeking to meet urban health care demands in more detail. At this local scale, it is evident to see how the broader shifts characterised in this section play out on the ground.

### **Voluntarism in and of cities at the local scale**

Beyond the broad international comparisons of voluntarism in urban health and social care across countries, urban geographic work has also examined the voluntary sector at the local scale within cities. A concentration of organisations are found *in* cities when compared to less dense areas, perhaps even an 'over' concentration, which is typical of most social and health infrastructure. We distil four key policy trends which have shaped how this voluntary

provision has been enabled or constrained: personalisation, localism, preventative voluntarism, and austerity. As we shall examine, these trends have shaped voluntary sector efforts to tackle the health demands in cities; but likewise, the supportive currents of the voluntary sector has shaped the freedom to which city authorities have invoked more punitive measures such as austerity cutbacks on certain populations, for example homeless people (DeVerteuil 2012). The sector also faces complex urban processes such as gentrification-induced displacement, community opposition politics with community care (e.g. over the location of drug treatment centres), as well as inner-city deprivation. These two factors (state policies and urban processes) compound to affect where voluntary organisations locate in cities.

At the local scale, it is also possible to examine the embeddedness of voluntary organisations, as part *of* urban communities and their relationships with local, regional and national political contexts. Voluntary organisations are understood by urban scholars to be of cities in terms of their spatial and cultural proximity (i.e. being imbued with urban residents' cultural values), their density within urban neighbourhoods, and the degree of solidarity that they can cultivate with their constituency. Urban Marxist sociologist Manuel Castells (1983) suggests that struggles over urban goods and services – what he termed collective consumption goods (e.g. health care, public housing) – ultimately shapes how people come together to create new possibilities, through urban social movements, to create the city. Castells (1983) referred to this landscape as 'the city and the grassroots'; comprised of urban-orientated mobilizations that influenced structural social change and transformed the 'societal hierarchies which structure urban life and create, instead, a city organized on the basis of use values, autonomous local cultures and decentralized participatory democracy' (pp.319–20). More empirical examples are used in this part of the chapter to 'provide depth' to our broader overview in the first part.

The majority of work in this field has focused on the provision of community care services as this has evolved to become the mainstay of voluntary sector activity. From the literature, it is possible to delineate four key policy trends which have shaped *how* this voluntary provision has been enabled or constrained: personalisation, localism, preventative voluntarism, and austerity. Each of these are examined here, tracing how they have set different priorities for the sector – on the one hand opening up new opportunities and on the other, posing significant urban health challenges which voluntary organisations have to respond to.

As stated, urban geographic work on the four key policy trends have largely evolved from a focus on the changing landscape of community care within cities. This has involved a constant recalibration of state, voluntary and private sector involvement. From the 1970s, a resilient yet patchwork ‘landscape of care’ emerged in the wake of large institutional closures (Power 2010; Milligan and Wiles 2010; DeVerteuil 2015). This landscape included a vast infrastructure of designated day care centres, intermediate care facilities, sheltered workshops, campuses, shelters and residential care homes (‘group homes’) within cities. This landscape was never fully complete and was often stigmatised by community opposition groups, becoming known in some cities as ‘landscapes of despair’ (Dear and Wolch 1987), drawing on work in Ontario. More recent work has examined the complex biopolitics involved in shelters governing homeless people in Hamilton, Canada (Evans 2011), and the complex spaces of inclusion/exclusion in drop-in centres for people with mental ill health in Scotland (Parr 2000).

Reflecting the breadth of this landscape, a body of literature developed around welfare geography and public facility location theory (see Joseph and Phillips 1984), which concerned itself with the question of where best to locate public facilities given equity and efficiency constraints, involving issues of distance, accessibility and locational conflict (DeVerteuil 2013). Whilst often written from normative perspectives, collectively this body of work demonstrates the visibility and extent of designated built ‘care spaces’ in the community. Since this time, there has been a steady erosion and deconcentration of this landscape piece by piece and a de-coupling of responsibility from the state in the commissioning of care placements. This has been characterised by the steady vanishing of care sites within cities for certain populations, such as day care centres, sheltered workshops, and training centres for those with intellectual disabilities (Dunning 2010; Mencap 2012; Needham 2015; Yoder 2012). And where sites remain open, they are often targeted at those with the highest support needs. These changes have become most evident in cities in England, the US and Canada.

This trend has largely emerged as a downstream effect of *personalisation* (‘self-directed support’ in the US) and its focus on granting more ‘choice-and-control’ to citizens. Personalisation emerged as a reforming concept, in part from the legacy of disability activism, which shifted the emphasis beyond what *service* people want, towards what *life* people want (Power and Bartlett 2015). This vision has been facilitated through the evolution of ‘personal budget’ models where individually-earmarked portions of the state social care

budget have been carved up and directly allocated to people to buy their own support through a market-place of providers (Hall 2011). Support is thus becoming re-framed from ‘care’ in care settings towards an effort at enabling meaningful lives nested in local neighbourhoods. This has naturally changed the emphasis from relying on state funded/provided care towards the individual ‘shopping for support’ from voluntary and private sector agencies.

Alongside personalisation, *localism* has seen increasing expectations being placed on family, voluntary and community groups to care for their communities and its local institutions, from libraries to drop-in centres (see Deverteuil 2003 for the American context). Localism has been observed as an active ingredient in policy imperatives to download responsibility for care and support, for example within restructuring health care systems of North America that call for ‘local integration’ to meet place-specific needs. It is also seen in resistance strategies of communities and community members in defence of local interests in the face of structural changes that obligate families and volunteers to play new roles in the health and social care system. In their study of media representations of voluntary sector responses to local healthcare integration policies in Ontario, Skinner, Joseph and Herron (2013) reveal the various ways in which the voluntary sector is called upon to defend the autonomy of the community against the perceived threats to local services, employment and vulnerable populations. They interpret the evident complexity of voluntary sector responses as a form of ‘defensive localism’, whereby voluntarism is subjugated as part of the valorisation of ‘local’ within both policy and public discourses (Woolvin and Hardill 2013).

Related to localism, we would argue that there has been an increasing policy emphasis in many cities on ‘*preventive voluntarism*’ in social care. In the US, this has been typified by the National Prevention Strategy which has advocated more empowered and motivated individuals and their communities to take a more leading role in active living and making more healthy choices. Another example of preventive personalized care and perhaps a more positive one has been the development of ‘Housing First’ programmes across many US cities. These are voluntary led programmes, funded by grant aid and voluntary fundraising, that put homeless people in housing first, then provide services, rather than giving them services to reform them while they wait long periods of time for housing (DeVerteuil 2014). In particular, the initiative seeks to serve chronically homeless individuals with co-occurring serious mental illness and substance use disorders. By not requiring sobriety or treatment/service compliance as a condition for programme entry or service continuation, it

genuinely can allow people to meet their basic housing needs while being guided to achieving their recovery goals (Watson et al 2017).

Similarly, the UK government has stated its intent on expanding (or perhaps relying upon) preventive voluntarism in the form of supporting welcoming communities to provide social support:

Supporting active and inclusive communities, and encouraging people to use their skills and talents to build new friendships and connections, is central to our vision for care and support. (DH 2013: p. 22)

Inherent within the above policy is a call to re-establish a notion of the common good. This has been mirrored by new preventative duties in recent legislation – the Affordable Care Act in the US (2010) and Care Act in the UK (2014). Both Acts now place a duty on states/local authorities, commissioners and insurers of *preventing* needs for care and support. In the UK for instance, the statutory guidance for the Care Act encourages co-production with communities and voluntary organisations as a local approach that can help statutory authorities meet these new duties where professionals and citizens share power to design, plan, assess and deliver support together. Similarly, the NHS (2015) Five Year Forward View also talks about the need to ‘harness the renewable energy in communities’. This new policy direction rests on the empowerment of local communities founded on voluntary networks of trust and mutuality.

The guiding principles of personalisation, localism and preventative voluntarism reveal the enduring legacy of the ‘panacea’ narrative, continually shaping positive aspirations for a renewed voluntary sector. However, increasingly scholars have been arguing that these policy goals have come into the cross-hairs of *austerity*. While the first three policy goals have increased expectations on the sector, austerity has meant that state funding has not kept pace with such expectations. Indeed, in many cases it has declined. It is here that the effects of ‘precarity’ is most evident. Growing evidence of austerity-derived cutbacks to municipal authorities is being seen across Europe, Australia and North America, resulting in what Peck (2012) argues is a new form of ‘austerity urbanism’. Roulstone and Morgan (2007) pose the question of whether personalisation is itself a co-opted liberal agenda to further wither collective welfare provision.

While the four policy trends above are not necessarily ‘new’, we argue firstly that they have entered new stages in their depth and breadth of reach and secondly, that they have become

increasingly entangled and intersected with each other, thus creating new forms and new spaces entirely. One notable contribution to understanding the effects of occupying these new spaces on the ground has been DeVerteuil's (2015) work on resilience in the post-welfare inner city. DeVerteuil focuses on voluntary sector organizations serving the street-homeless population through emergency housing and outreach services in Sydney, Los Angeles and London. These services have been situated historically in inner-city locations to reach their client-base and as such are very much *of* the city. However, with rising levels of homelessness and increasingly unaffordable housing across these cities, the current environment presents a critical conjuncture for these organisations, putting them at greater risk of displacement. To compound these issues, the neighbourhoods in which these services are based also face significant gentrification pressures on the one hand and hostile welfare reform strategies on the other. Such organisations offer potent examples of resilient practice, as many are remaining in place despite these challenges. While the sector may not be transgressive in its own right, such resilience offers a platform for mobilising other forms of resistance against such pressures.

The intersection of austerity and preventative voluntarism has also been examined, where work has focused on the complex relationship that unfolds between local voluntary organisations, volunteers and their local communities (e.g., in Ireland, see Walsh et al 2015). Over time, to reflect the growing emphasis toward partnership working and governance between the state, market and voluntary sector, the meaning of voluntarism has shifted towards incorporating more entrepreneurial, professionalized practices on the ground (Morrison 2000). It is at this scale that the broader tensions around the managerialism and co-option of the sector can play out. James' (2014) ethnographic work with young people in a deprived inner-city region in London for instance gives an indication of the sensitive relationships that unfold between young people, the state, and local volunteers working in voluntary sector youth clubs.

He found that the young peoples' lives in such areas are characterised by deprivation, poverty, low educational achievement and unemployment (Runnymede Trust 2002 76-89, cited in James 2014: 20). A context of cutbacks and criminalisation were also formative conditions of their lives. From 2007, it was the end of the New Labour era of 'partnership' with the non-profit sector and the beginning of the 'cuts' to health and social care and local authority funding. At the same time, a summer knife crime epidemic hit London in 2008, followed by the English city riots in 2011. These incidents illustrate the extent that young working-class



people feel alienated, nihilistic and disengaged from local urban politics and community life. Such experiences are expressed through urban ‘grime’ music (e.g. Giggs, *Talking the Hardest*, 2009), that communicates territorial warfare, anti-social and apolitical principles – as well as political critiques of their marginalisation and the social injustice that they experience.

With this background, voluntary sector young clubs are important spaces in tackling issues of mental health, wellbeing and anti-social behaviour in the city. Often, such organisations had previously belonged to the local authority, but had been handed over to voluntary sector organisations. Youth workers (paid volunteers) within these clubs are involved in encouraging community participation and local forms of citizenship that could reduce crime and increase local wellbeing and empowerment amongst the young people. Given the sparsity of other opportunities and welcoming spaces, James argues that the youth club has a territorial dominance in young people’s local landscapes. Despite their important role, his ethnographic work reveals how they now have become spaces where police and community support workers develop closer partnerships that seek to control and contain young people’s lives. One local youth club he reports built an 8-metre-high fence, made of steel bars and enclosing the perimeter of the youth club. The fence accompanied increasing levels of policing at the youth club. With the cuts, many youth clubs began to lose their autonomy and revenue stream, and were increasingly being co-opted into working as an informal site of the criminal justice system. Youth workers were expected to share information with the police, for example on local ‘trouble makers’ likely to have caused recent burglaries in the area. At one youth club, partnership meetings between police and youth workers resulted in changing the opening hours to a longer day, to discourage anti-social behaviour in the evenings. Talks were hosted where police officers could attend youth club sessions to ‘improve their relationships’ with the local youth. While some volunteer youth workers approved of these initiatives, others were sceptical and concerned that a hard-won trust was being eroded as young people saw youth workers as siding with the ‘enemy’ (James 2014, p. 94). Such work illustrates the challenging contexts in which some voluntary organisations have to work in supporting health and wellbeing of young people in inner-city areas. There is also an anticipatory urban geographies to consider when examining the ‘agency’ of volunteers running voluntary sector organisations within harsh funding climates. Horton (2016) found that the constant threat of further cuts was having a significant effect on volunteers’ morale and the likelihood that they would stick with their jobs.

In the Global South, as we saw in the previous section, there can be a different set of health issues within cities derived from greater risks to communicable diseases associated with poor sanitation, pollution, over-crowding and poor housing conditions including squatter settlements, and increased risk of road traffic accidents (Harpham 2009). As urban populations increase, these factors will likely exacerbate such challenges for health services.

Given these overwhelming challenges, the World Health Organization (WHO) understandably has a clear remit, and has advanced many initiatives to try and tackle urban health (e.g. Urban Health Equity Assessment and Response Tool 'HEART' and 1000 Cities project to call upon 1000 cities to open up public spaces to people to encourage more healthy activities). The main intervention that has tried to tackle urban health in an explicitly multi-sectoral way involving voluntary organisations is the beleaguered Healthy City initiative, promoted by the WHO. In its objectives, there is a clear recognition of the need to include the voluntary sector: (objective 1) "Political mobilisation and community participation in preparing and implementing a municipal health plan", and (objective 3) "formation of partnerships with communities and community-based organisations (CBOs) in improving living conditions in poor communities" (WHO, 1995). However, the implementation of the concept has struggled in the South due to political will and a reliance on outside donors (Harpham 2009). Also, while NGOs are there to fill gaps, they do not always do so in an appropriate or high-quality manner as they are largely uncontrolled (Harpham 2009). At the local level, municipal mistrust of NGOs and CBOs is also sometimes a block to scaling up successful pilot projects and too few pilots get scaled up to the point of achieving economies of scale for large populations. Harpham (2009) points to some exceptions to this, where partnerships have worked well. The Bangladesh Urban Primary Health Care Project, covering six cities and five towns, is one example of a successful partnership. The project (funded by various development banks, the UN, and aid organisations) contracts out primary health care to 16 local NGOs (referred to as the private sector) and 30% of activities are targeted to the urban poor. Each NGO covers a catchment area of about 300,000. The national Ministry of Local Government manages the project and the total cost is around US \$40 m. This is perhaps the most significant example of local, national and international voluntary and state partnerships in the field of urban health.

Given the complexities involved, the assumption that voluntary care occurs 'naturally' in communities has largely been critiqued, particularly in the global South (Miller 2013), as they are often based on long-held community ideals which tend to over-simplify the complex

relationships involved. In reality, given often high levels of inequality and residual state involvement, often the voluntary sector operates solely via private fees and charges. In Rio de Janeiro, a survey of non-profit organisations revealed that fees and charges are more important than government funding or funds from abroad in financing non-profit activity (Landim 1998).

Returning to more general debates in urban geographic scholarship concerning voluntarism in health contexts, there has been a large focus on the uneven geographic spread of voluntarism within cities. Scholars such as Wolpert (1977), Wolch (1990), and Fyfe and Milligan (2003) have each uncovered the uneven spatial distribution of voluntary provision and the inverse care law in the context of voluntary community care. The inverse care law refers to the phenomenon that in areas that need the most community support, voluntary activity is typically low and vice-versa. More recently Mohan's work on civic engagement in 'Big Society' Britain (Mohan and Bulloch 2012) has helped identify the different sections of the population who traditionally participate in charitable giving, volunteering, and participation in civic associations. His work found that a small group of people contribute a large proportion of formal civic engagement. This group can be thought of as the 'civic core'. A third of the population provide 90% of volunteering hours, four-fifths of the amount given to charity, and nearly 80% of participation in civic associations. The social characteristics of members of these 'core' groups are analysed, showing that members of the 'civic core' are drawn predominantly from the most prosperous, middle-aged and highly educated sections of the population, and that they are most likely to live in the least deprived parts of the country. As further illustrated in allied work on voluntarism in non-metropolitan (rural) settings of rural North America and elsewhere (e.g., Skinner 2008; Skinner et al 2016), this remains the paradox for those implicated in urban health care delivery as well as for urban geographic scholars seeking to understand the impacts of the policy landscape determined to broker new voluntary sector contracts. For some constituencies, such as people with intellectual disabilities, the effects of cuts to state provided support and a reliance on charity, has simply meant that more people are stuck at home (Mencap 2012), with only occasional peer-support opportunities to share meaningful social encounters (Power, Bartlett and Hall 2016). As we stated at the outset, while voluntarism has proved to be a relatively resilient sector over time, it is ultimately precarious in certain areas and in the face of a threadbare and volatile (and paradoxical) funding landscape.

## Discussion and Concluding Comments

This chapter has served to illustrate the complex and varied landscape of voluntarism within urban health. We took as our starting point that urban health systems are wider than solely health facilities; in reality, they incorporate a myriad of different community resources, actions by individuals, and organisations which seek to improve the wellbeing of urban populations and enable them to cope with adversity. Within the diverse spaces in which such actors and institutions occupy, we have examined how voluntary organisations and the state negotiate and carve out complex calibrations of care and support, with consequences for how both are conceived and positioned vis-à-vis each other.

At the international scale, we first examined how such positioning operates at a macro-scale. Different nations have advanced liberal, socio-democratic and corporatist regimes of welfare, each with subtly different sets of expectations and assumptions over the role of the voluntary sector. More recently though, these formerly distinct regimes are converging in their policy towards austerity politics and a commitment to foster greater levels of volunteering in order to fill the gap in statutory provision. Work in the global south has also shown the discernible trends operating around the governance of health and social care in contexts of steep inequality and often complex political terrain. At the national scale, in each case, the examination of different case-studies has helped to identify how these macro-level regimes play out in different countries.

Moving beyond these wider observations, the second half of the chapter focused more on voluntarism *in* cities and the urban health systems that they contribute to. At this scale, it is finally possible to examine the complex relationship that has unfolded between voluntary organisations, volunteers, the state, and local communities. Here, being part *of* the urban infrastructure and its local population is also evident. Delicate negotiations can sometimes be necessary, as voluntary groups must serve and be trusted by their constituency (e.g. younger versus older people), and be sustainable and accountable to the state. Urban geography work has shown how these negotiations become challenging in contexts where urban space is marked by various pressures around gentrification and austerity. Such work has also revealed the implications of relying on a sector that by default is more de-centralised and organic, but in trajectory is only now being understood as a sector in transition from *panacea* to *paradox* to *precarity*.

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