Introduction

Underlying a recent ‘voluntary turn’ in the health and social sciences is the importance of understanding how voluntary sector activities are manifest quite differently among and within particular places. The emergent field of ‘geographies of voluntarism’ (Fyfe and Milligan, 2003), however, remains almost explicitly the domain of American and British research with allied work from Canada, Ireland and New Zealand, etc. (see contributions to Milligan and Conradson, 2006). Such exclusivity is a crucial challenge for disciplinary progress, and key commentaries are calling for the expansion of geographical research on voluntarism beyond the English-language context of Anglo-American (and Antipodean) welfare states (Milligan, 2007). For instance, as Skinner and Joseph (in press) point out, it is unclear if the dominant concepts and theories about voluntary sector activities are applicable to understanding health care across the international continuum of welfare systems. This raises a critical question for health policy, research and practice, namely, how informative are the prevailing views of the geography of voluntarism?

In this paper, we address this question and expand the scope of geographical research on voluntarism as it relates to health care by examining the under-researched French context of the économie sociale et solidaire and its involvement in the secteur médico-social. Specifically, we apply an existing theorization that problematizes the place-specific activities of voluntary organizations and volunteers as a multifaceted response emerging from the socio-demographic challenges of population ageing and the structural changes underway in the health care system (Skinner and Joseph, 2007; in press). We do so for the purpose of interpreting findings from a case study of local
associations providing and advocating for volunteer-based services in the ageing communities of Maine et Loire, a département comprising a mix of urban, rural residential and agricultural settings within the Pays de la Loire region of western France. The case study is informative because it is set within a comparable national context of demographic transition and structural transformation, yet the historical and philosophical foundations of the économie sociale et solidaire are quite unique (Archambault, 1997; 2001). Moreover, with a rising proportion of older people that is above the national average, an historically strong role for associations locally and a longstanding reputation as a leader in regards to health and social care (Fleuret and Skinner, 2010), Maine et Loire provides an important view of the under-researched context of health voluntarism in France.¹

With specific attention to local activities and initiatives, our objective in the pages that follow is to elucidate from a French perspective (i) the emergence of associations within evolving spaces of care; (ii) how they facilitate adjustment to change at the local level and create spaces of resistance for shaping local outcomes; and (iii) the complexity underlying their changing roles in ageing communities. In considering the empirical realities versus theoretical expectations of the économie sociale et solidaire, we highlight avenues for theoretical adaptation and prospects for achieving a more inclusive health geography of voluntarism. We begin by situating the research within health geography’s voluntary turn and the distinct context of voluntarism in France.

¹ Terminology unique to the French context is italicized throughout. Specifically, économie sociale et solidaire and associations are similar but not synonymous with voluntary sector and voluntary organizations, respectively; secteur médico-social involves health and social care services for youth, older people and individuals with disabilities, which are separate from the secteur de la santé involving medical services in hospitals and clinics (i.e., services médicaux de santé); and département is an administrative jurisdiction roughly equivalent to a county level of government in North America and the UK.
Health geography’s voluntary turn

Our investigation into the evolving role of the économie sociale et solidaire with respect to the secteur médico-social in France begins with the observation that, with a handful of exceptions notwithstanding (Jenkins, in press), geography’s voluntary turn is confined to the contexts of Anglo-American-Antipodean welfare states. The disproportionate emphasis is not surprising given that the field of study evolved within American and British geography, from initial spatial analyses of volunteering and philanthropy in the 1970s, into the critical study of voluntary sector formation as a shadow state in the 1980s and the place of voluntarism within the restructuring landscapes of health and social welfare in the 1990s (see Milligan, 2007). In the 2000s, progress in the field involved a number of major contributions from geographers concerned with how voluntarism relates to variations in civil society and place formation, new spaces of governance and activism, as well as understanding inequality, health and wellbeing (Milligan and Conradson, 2006). Underlying these developments has been an enduring emphasis on health and health care as both the context and subject of inquiry. What is surprising is that, despite longstanding connections and co-developments among the various national geographical traditions, there remains a considerable paucity of research on the geographical dimensions of voluntarism in non-English-speaking countries (Fleuret and Skinner, 2010). Such is the case, especially within Western Europe, where there is already a large body of social science scholarship on the voluntary sector in countries like France, Germany and Italy (Salamon et al., 1999).
Any consideration of health voluntarism internationally, however, must first acknowledge the heterogeneity of what is often interchangeably called charitable sector, non-profit sector, social economy, third sector and voluntary sector, etc. Each of these is a form of civil society in that they are not part of the state, but they have very different philosophical foundations and historical-geographical traditions (Laville et al., 2002). Indeed, the endeavour to redress the resultant lack of consensus about the societal role not to mention the geographical scope of voluntary sector activities has been poignantly referred to “chasing a loose and baggy monster” (Bryson et al., 2002: 48 following Kendall and Knapp, 1995). There is no literal translation for our empirical focus on économie sociale et solidaire in France, for instance, which comprises four types of civil society organizations (cooperatives, mutuelles, associations and fondations)\(^2\) that are positioned between the private (business) sector and the public (government) sector (Archambault et al., 1999), and traditionally play a minor role in service provision relative to other welfare states (Bode, 2006). Voluntarism is further complicated in regards health and health care, where it generally involves a mix of organizations, groups and individuals across the continuum of formal services, community support and informal care, who operate at international, national and local scales, but do not view themselves as a homogenous group of stakeholders (Skinner and Rosenberg, 2006).

Against this backdrop, the starting point for the body of geographical work on voluntarism as it relates to health and social care is the ongoing call to scrutinize the axiom that voluntary organizations and volunteers have the capacity and willingness to resolve the fiscal crisis facing contemporary health systems, while at the same time

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\(^2\) These are roughly equivalent to cooperative organizations, mutual-aid societies, community non-profit organizations and charitable foundations, respectively.
fostering civic responsibility and engagement in the provision of home and community care (Milligan, 2007). Central to this critique are the attendant efforts to theorize and document empirically the implications for and consequent responses of voluntary organizations and volunteers. Key studies, for instance, demonstrate how the complex and interrelated changes relating to demographic ageing, restructuring and voluntarism point to the importance of understanding the local, place-specific experiences of the voluntary sector (Milligan, 2001). Attention has been drawn to the importance of volunteer-based activities in the formation of new spaces of resistance to structural changes in particular (e.g., activism in the face of proposed health reforms) (Owens and Kearns, 2006). It is here where the particular theoretical problem that we engage in this paper emerges; that is, the gap in understanding how the voluntary sector is coping with the challenges of increased responsibility for providing care in ageing communities.

For an example of work on this problem within the Anglo-American-Antipodean context, we turn to a recent theorization of voluntarism as a multifaceted response to evolving socio-demographic demands and more immediate structural imperatives. Drawing on research on ageing communities in Canada and New Zealand, Skinner and Joseph (2007; in press) situate voluntarism at the intersection of long cycles of change underway in technology, demography and lifestyle versus shorter-term cycles of change flowing from economic and social restructuring, which together challenge the overall sustainability of health and social care, and that of aging in place in the community. Their central focus is on understanding how the ‘local dynamics of voluntarism’, involving complex interactions among voluntary organizations, community groups, family members and individual volunteers, shape local outcomes of change. To advance
research into this area, the authors theorized voluntarism concurrently as a ‘barometer of change’ underway in communities facing demographic and health system changes, a ‘mechanism of adjustment’ through which these changes are accommodated locally by voluntary organizations, groups and volunteers, and a ‘space of resistance’ in which they actively contest the processes and outcomes of long and short cycles of change. This tripartite view of voluntarism contributes not only to understanding the potential for healthy ageing in communities at the intersection of demographic trends and service restructuring, but to unpacking the complex public-private, formal-informal matrix of contemporary health and social welfare (Curtis and Riva, in press).

With its explicit framework for conceptualizing and interpreting findings about the local dynamics of health voluntarism, Skinner and Joseph’s (2007; in press) theorization is especially suitable for our present examination of the économie sociale et solidaire and secteur médico-social in France. Underlying our interest is initial evidence of the clear expectation that voluntarism will play a new role in meeting ageing-related demands for care in general (i.e., a barometer of change), and of the discrepancy between ideologically-based policies and empirical realities that suggests associations in France are already actively involved in accommodating and contesting the implications of ageing and restructuring (Fleuret and Skinner, 2010). Specifically, in terms of understanding the intersection of demographic trends, service restructuring and voluntarism, the latter components of the theorization can be applied to interpret the evolving role of associations as a negotiation between making adjustments to accommodate change, such as taking on government contracts to deliver services for older people in the community, versus taking actions to resist the changes underway in the secteur medico-social, such as
creating alternatives to formal services to enhance the independence of older residents as they age in place. Following Skinner and Joseph (2007; in press), these types of responses are viewed not as mutually exclusive; rather they are part of complex, often reciprocal expressions of voluntarism in particular places. From this perspective, a comprehensive understanding of voluntarism requires an appreciation of the distinctiveness and duality of its multiple facets. Before we can evaluate how these theoretical expectations play-out in regards to the *économie sociale et solidaire*, consideration must be given to the broader context of voluntarism in France.

**French context of voluntarism: *économie sociale et solidaire***

France has not been immune to the burgeoning political and intellectual interest in the potential of voluntarism. In response to similar socio-demographic and fiscal challenges facing other welfare states, the debate about the potential of the *économie sociale et solidaire* and its constituent *associations* to expand and formalize their role in service provision has been underway since the late 1990s (Deibolt, 2002; Revue du MAUSS, 1998). In general, along with a rapidly ageing population, a restructuring health system and the relatively recent endorsement of neoliberal policies, the emergence of a voluntary turn in France can be seen as paralleling that underway in North America and the UK (Bode, 2006). Much like the British engagement with the metaphorically ‘loose and baggy monster’, for instance, there is a small body of scholarship bringing conceptual and empirical coherence to the geographical dimensions of the *économie sociale et solidaire* (Observatoire National de L’ÉSS, 2009).
In terms of its scope, voluntarism in France is considerable but not extraordinary. Relevant findings from the Johns Hopkins Comparative Nonprofit Sector Project (Salamon et al., 1999), for instance, estimate almost four percent of gross domestic product and five percent of total employment are accounted for by the *économie sociale et solidaire*, which places France just above the mean average contributions of equivalent voluntary sectors in Europe and North America. Similar to other countries, the majority of contributions are in the fields of culture and recreation, education and research, and health and social services, with these sectors accounting for more than 80 percent of *économie sociale et solidaire* organizations, expenditures and full-time equivalent employment (Archambault et al., 1999). Of particular relevance is the critical role in the *secteur médico-social*, where the *économie sociale et solidaire* currently provides almost 65 percent of services in the sector (Observatoire National de L’ÉSS, 2009).

Supplementing these figures are the typically unmeasured contributions of the estimated 15 million *bénévoles* (volunteers) who are critical to the *économie sociale et solidaire* but have no formal recognition within the French system (Archambault et al., 1999). In the *secteur médico-social*, which is heavily reliant on *bénévoles* to provide services, the implications are that the actual role of voluntarism is underestimated and the essential contributions of volunteers are often invisible (Fleuret, 2006).

What distinguishes the French context is the unique historical-geographical trajectory of the *économie sociale et solidaire*. As elsewhere in Western Europe its roots date back to the Middle Ages but, contrary other European voluntary sectors, its development was systematically repressed by the state until the early 20th-century (Archambault, 1997). In brief, the *économie sociale et solidaire* can be traced from its
Medieval foundations in the charitable and mutual aid missions of the Catholic Church and guilds; to its secularized and highly restricted role in serving the public interest within the centralized state following the 1789 Revolution; its relatively late modern development into a formal sector with the promulgation of the loi de 1901 granting legal status to coopératives, mutuelles, associations and fondations; its growth as part of the post-WWII welfare state, especially after national decentralization in the early 1980s; and its current prominence in certain service sectors following European integration and subsequent reforms that formally endorsed voluntarism and privatization (Archambault, 2001). Unlike other parts of Europe that have embraced voluntarism as a panacea for the problems facing the welfare state (Bode, 2006), the full development of the économie sociale et solidaire into the provision of services like health and social care remains constrained by a legacy of restrictive policies (Archambault et al. 1999). In 2010, the legacy is evident, for instance, in the creation of new Agences régionales de santé (ARS) and the promulgation of the loi hôpital, patient santé et territoire (HPST) aimed at re-centralizing health planning and restricting the role of the économie sociale et solidaire to project-based funding contracts (contrats d’objectifs et de moyens), which have the potential to redistribute and even institutionalize some services currently delivered by association such as support for people with disabilities.³ It is against this backdrop that the involvement of associations within the secteur médico-social must be situated.

To attain the goal of a national solidarity, the French welfare system is based on a set of social insurances guaranteed by the state covering health, employment, family and ageing (Damon, 2009). These insurances are actualized through financial compensations

³ While similar to health and social care reforms that have affected the involvement of the voluntary sector in other jurisdictions (e.g., Cloutier-Fisher and Skinner, 2006), it is too early to assess the implications of the ARS and HPST for the économie sociale et solidaire.
for specific problems (e.g., disabilities) in the form of subsidies for individuals, funded by the national government and a combination of upper and lower-tier governments (i.e., région, département and municipalité). Individuals who can benefit from subsidies, purchase these services directly from a complex patchwork of public sector agencies, private enterprises, mutuelles and associations, the combination of which differs among sectors. There is no role for associations in regards to formal medical services (services médicaux de santé), for example; however, they do play a major role in health promotion and prevention (Diebolt, 2002). Responsibility for planning and coordinating services among these sectors is shared among the lower-tiers of governments in variable proportions depending on local circumstances (Rivard, 2006). For instance, services for older people are the responsibility of département, which are charged with establishing optimal conditions for the integration and coordination among the government, private enterprises and associations (Chaudet et al., 2005). It is within this framework that associations are seen to play important if constrained roles in the delivery of médico-social services.

Despite the historical constraints, associations play an increasingly significant role similar to other developed counties in Europe and North America. In some départements, for instance, up to 70 percent of all médico-social services are delivered by associations, especially services for the elderly or people with disabilities such as home care and meal programs (Chaudet et al., 2005). Important changes, however, have been underway since the 1970s, particularly in terms of the evolving role of bénévoles from direct service workers to leadership positions on boards of directors (i.e., from ‘action’ to

4 Administratively, France is divided into 26 régions (including Pays de la Loire) that are comprised of 100 départements (including Maine et Loire), within which there are 36,781 municipalités (including Angers).
‘orientation’ work) (Forse, 1984). As with the professionalization of volunteer-based services in other countries (Salamon et al. 1999), the management and direct provision of services in France it has been increasingly entrusted to salaried staff instead of the traditional reliance on volunteers (Rivard, 2006). Similarly, the role of associations has also changed because of restructuring that began with decentralization in the 1980s and culminated in reforms to the health system into the 2000s (Archambault, 2001). As a result, *département* are now compelled to establish optimal management and coordination of services for youth, elderly people and people with disabilities (Chaudet et al., 2005). Primarily rationalized as a means of achieving spatial equity, the underlying devolution of responsibilities is now directly related to the arrival of the neoliberal ideology in France carrying with it the idea that the national state had to drastically reduce its expenditures relating to public services (Damon, 2009). One of the combined impacts of decentralization and devolution was the emergence of the *économie sociale et solidaire* as a formal component within the welfare system (Archambault et al., 1999). The latter was reinforced in recent legal reforms granting individual tax credits for expenditures relating to volunteering. The 2006 *loi Borloo* (personal services law), for instance, created new opportunities for private and voluntary sector involvement and, in essence, opened the door to the type of formal endorsement of voluntarism found in other developed countries.

Altogether, these trends have placed the *économie sociale et solidaire* at a cross-roads between its independent but often limited role in the provision of *médico-social* services and the new opportunities to develop within the institutional planning framework of lower-tier levels of government (Fleuret and Skinner, 2010). Despite the historically
and geographically distinct foundations, *associations* now face the same predicament as their international counterparts. That is, to keep their independence at risk of losing funds and being less visible or to provide services at risk of being institutionalized within a neoliberal regime that, for the most part, favours private sector provisioning (Milligan, 2007). It is with this historical-geographical trajectory in mind that we turn to the question of whether prevailing health geography perspectives on the local dynamics of voluntarism are transferable to the empirical case of the *économie sociale et solidaire* and its involvement in the *secteur médico-social* in France.

**Case study in western France**

Our empirical investigation focuses on the results of research on local *associations* involved in the *secteur médico-social* in the ageing communities of the Pays de la Loire region, western France. The specific case study, Maine et Loire (pop. 732,000), is located approximately 300 km southwest of Paris and is centred on the urban *municipalité* of Angers (pop. 150,000) (Figure 1). The case study is informative for building understanding of local dynamics of voluntarism because the activities of *associations* in support of the *secteur médico-social* are situated in a local context that is representative of the socio-demographic transition and structural changes underway across France (Fleuret and Skinner, 2010). Particularly useful for our purposes, is the opportunity to study voluntarism in a *département* comprised of urban, rural residential and agricultural communities that have longstanding services for older people and an established *économie sociale et solidaire* locally, which is not always the case in other parts of France (INSEE, 2007; Observatoire National de L’ÉSS, 2009). Our aim is not to
elucidate the effects of place, which would require another type of analysis, but to provide a local example of health voluntarism in an under-researched national context, thereby setting an important foundation for future research on *économie sociale et solidaire* both within France and internationally.

The case study is part of ongoing research led by the second author into how *associations* are meeting the health and social care needs of the population at the local level (Chaudet et al., 2005; Fleuret, 2003; 2004; 2006). It features a multi-phase, mixed-methods strategy of inventories, surveys and interviews with local *associations*. Empirically, the aim of the research is to address the gap in information about the scope of and interactions among public agencies, private enterprises and *associations* providing health and social care for older people at the local level. The research is important because, notwithstanding the recent atlas of *économie sociale et solidaire* (Observatoire National de L’ÉSS, 2009), the current state of knowledge about *associations* in France remains incomplete, especially in regards to the *secteur médico-social* (Diebolt, 2002).

Beginning in 2003, the initial phase of the case study involved developing an inventory of the 458 *associations* actively involved in Maine et Loire. Based on a review of existing legal, professional and government databases, the inventory provided the first comprehensive typology of *associations* within the *secteur médico-social* at the local level in France (Fleuret, 2003; 2004). The case study continued with a quantitative investigation into activities and interactions within the *secteur médico-social*, with representatives from 115 *associations* completing a semi-structured telephone survey. Acknowledging the relatively limited response rate (25%), the survey established key trends relating to the activities and interactions of *associations* in Maine et Loire.
(Chaudet et al., 2005). In the final phase, a series of in-depth interviews were carried-out with a purposive sample of key-informants recruited from 16 associations that participated in the survey and represented the different types of health and social care services provided locally in the département (Fleuret, 2006). The strength of case study lies in it comprehensive analysis of how local associations from across the range of health and social care services are responding to the increasing demands for care amid structural imperatives to take on new roles in the secteur médico-social. To minimize researcher bias, the interviews were recorded and transcribed to ensure data accuracy and, for the purpose of this paper, English-language translations of specific quotations are used to authenticate the participants’ views. All identifying information is omitted, however, to ensure the participants’ confidentiality and anonymity.

Taken together, the inventory, survey and interview results constitute the empirical focus of our endeavour to evaluate the applicability of the local dynamics of voluntarism theorization. In line with Skinner and Joseph (2007; in press), the findings from Maine et Loire are presented below with an eye to understanding the evolving role of the économie sociale et solidaire as a multifaceted response to ageing-related demands for services and imperatives of the restructuring health system in France. The analysis has three parts, moving from a description of the emergence of associations within the evolving spaces of care in Maine et Loire, to an interpretation of how they act as facilitators of change at the local level (i.e., a mechanism of adjustment) and as mediators of opportunities for shaping local outcomes (i.e., a space of resistance), and an examination of the complexity underlying their evolving, and at times contradictory, roles in supporting ageing communities.
Evolving spaces of care in Maine et Loire

The activities and initiatives of local associations in Maine et Loire must be understood in relation to the development of the secteur médico-social, the changing nature of the économie sociale et solidaire and the increasing propensity for ageing in place. The latter trend is symptomatic of the relatively large proportion of older people living in the case study region (Pays de la Loire), where 21% of the population is over 60 years old, and rising at a faster rate than the national average with the proportion of those over 60 projected to reach 31% by 2030 (ORS des Pays de la Loire, 2007). The implications of the latent demands associated with the older population are embedded in an evolving space of care (in essence, a complex web of practices, relations and experiences in various institutional, community and household settings that encapsulate health and care in particular places) that emphasizes an active and direct role for associations and bénévoles in service provision through formal and informal means. The consequent responses explored in the next section, thus, can be seen as emerging from the dual imperative to enable people to age in place, thereby sustaining local communities, while at the same time conforming to changes in the health system, thereby sustaining médico-social services (see Table 1).

Within this demographic context, and consistent with the endorsement of voluntarism and the économie sociale et solidaire within French health policy, local associations play an important role in the secteur médico-social in Maine et Loire. As shown in Table 2, the associations reported a range of activities including those relating to médico-social services (e.g., moral support, home care, social services and housing)
and services médicaux de santé (medical services). Indeed, the emerging role of associations must be understood in the evolving context of institutional versus community-based care in France (i.e., santé vs. médico-social). As in other health systems that underwent de-institutionalization, the evolution of the secteur médico-social and the attendant emphasis on home and community care, particularly in relation to the delivery of services and supports for older people, people with disabilities and other vulnerable people, can be traced back to the early 1970s. As noted above, since this time associations along with private agencies became formal (albeit relatively restricted) partners in service delivery not least of which because of their capacity to respond positively to local, place-specific needs.

This legacy is evident in the descriptive results from Maine et Loire. At the time of the research (early- to mid-2000s), 110 of the 115 of the participating associations (95%), were involved in providing médico-social services relating to the fields of social support (36%), disabilities (30%), elder care (21%), family support (5%) and wellbeing (4%), whereas only 60 (52%) reported involvement in services médicaux de santé relating to public health (26%) and specific diseases (25%). The scope of their activities is further complicated by the fact that many of them were involved in both health sectors. Indeed, the relatively less important role in the secteur de la santé is reinforced in that only one-fifth of the former group indicated that they provided some services médicaux de santé (21%) versus one-third of the latter group indicating that they provided some services in the secteur médico-social (34%). Driving the disproportionate emergence of voluntarism within the secteur médico-social is a political-institutional framework that favours regionally-planned public sector involvement in services médicaux de santé.
provided in institutional settings as well as the decentralization of fiscal and coordination responsibilities for médico-social services to the levels of département and municipalities and the divestment of service delivery responsibilities to private entrepreneurs, mutuelles and associations from the économie sociale et solidaire.

Alongside the immediate imperatives of downloading, devolution and divestment within the secteur médico-social, the development of associations must be viewed in relation to the changing nature of the économie sociale et solidaire. As noted earlier, the modern development of voluntarism in France can be viewed as part of the post-WWII welfare state (pre-1970), national decentralization initiatives (1970-1990) and recent neoliberal reforms emphasizing voluntarism in certain sectors (post-1990). As shown in Table 3, the rationale for establishing associations has evolved marginally through these contemporary phases from an original grassroots purpose to ‘compensate for a lack of information, support or service’ (from 66% pre-1970 to 36% post-1990) towards a more formalized purpose to ‘fulfil a system directive’ (from 3.7% pre-1970 to 19.5% post-1990) and even an oppositional purpose to ‘offer an alternative to the system’ (from 11.1% pre-1970 to 21.9% post-1990). Underlying these trajectories, which parallel the emergence and increasing complexity of voluntarism internationally, are a new set of challenges facing the économie sociale et solidaire, most notably, the potential crisis facing associations as they come to grips with their uncertain capacity to meet demands for services in the ageing communities and the very real threat of losing their autonomy by accepting government contracts within the increasingly formalized secteur médico-social. The precarious position of local associations is encapsulated best in the words of a key-informant from Maine et Loire who explained, “It is a balancing act...we benefit..."
from more public funding but we want to keep our freedom to provide services in our own way”. It is in unpacking how the balancing act plays-out locally that the concepts of adjustment and resistance become particularly effective in understanding the local responses of associations in Maine et Loire.

Local responses: adjustment, resistance, complexity

As summarized in Table 1, the associations can be seen as taking various actions to adjust and/or resist changes emanating from two phenomena: (i) the increasing demands for médico-social services associated with France’s ageing population and (ii) the more immediate expectation that the économie sociale et solidaire take on new roles and responsibilities associated with the structural changes in the French health system. It is at their intersection where association, and the économie sociale et solidaire more generally, can be seen as multifaceted and increasingly complex stakeholders in ageing communities.

Evidence of adjustment

The activities and initiatives of associations in Maine et Loire can be viewed as facilitating adjustment primarily to the changing expectations of the économie sociale et solidaire within the secteur médico-social. Their response strategies were centred on professionalization and the attendant decrease in direct involvement of bénévoles; quasi-institutionalization within the contracting scheme of the secteur médico-social; and local coordination of existing resources both formally and informally. As a result of the recent changes in the health system, associations have been asked to position themselves within
a new legal, administrative and territorial framework. This re-positioning required meeting new obligations to become professional in the planning, management, coordination and delivery of services. Along with increasing the operational costs associated with professional staff recruitment and training, the consequences for how associations support the community also included a paradoxical reduction in the active involvement of bénévoles as front line providers of care. As a key-informant commented, “Professionalism leads us to use less volunteers…they are not in the field anymore, they are reduced to the role of managing”.

Underlying adjustment through meeting professional obligations is the expectation that associations will conform to new contractual imperatives and, in effect, become quasi-institutional components of the secteur médico-social. On the one hand, the implications in Maine et Loire have been positive, in that associations have benefited from increasing public subsidies for services in the community and stronger relationships with the région, département and municipalité administrations have ensued, which a key-informant summarised as, “The state needs the associations and vice versa”. On the other hand, as intimated earlier, the associations are concerned about the potential loss of autonomy and the implications for the sustainability of the économie sociale et solidaire as a partner in the health system. Several key-informants were concerned about the push towards privatization, with one asking “Is it sustainable for the future if public funding is more and more conditioned to applications from for-profit, private entrepreneurs?”

The most pronounced evidence of adjustment was in relation to the developing local coordination initiatives to accommodate new expectations and obligations. Specifically, partnerships and networks were established by the associations to address
their limited capacity to cover the continuum of services, offer professional training and meet other administrative requirements such as increased accountability. As the key-informants pointed out, this was viewed as a particularly effective way to facilitate adjustment to the restructuring health system, with one explaining, “Partnerships are a means to compensate the withdrawal of the state by training volunteers and professionals collaboratively” and another that, “Locally it is about networking because we just don’t have the resources”. Networking to share information and expertise was seen as key for meeting contractual requirements to become more coordinated and accountable. These adjustment strategies were implemented both formally through the establishment of local association federations and informally among association managers, staff and community leaders.

In terms of meeting the ageing-related demands for services, as outlined earlier, associations are active in maintaining the independence of older people living in Maine et Loire. While this represents a de facto means of facilitating adjustment to changing population dynamics (e.g., “More people need our services because everyone is getting old”), the associations also can be seen as mediators of médico-social services at the local level by identifying specific vulnerabilities within the population and making applications for public funding to provide context-specific services. Several key-informants highlighted how the demographic challenges associated with ageing in the community have generated increasing demands for their services, especially in regards to older residents with disabilities. Underlying the imperative to provide more services is that in their absence older residents will increasingly move into établissements pour personnes âgées (elderly care homes) and in effect reduce the viability of ageing in place,
especially since almost one-fifth of people over 60 years are already living elderly care homes in the Pays de la Loire region (INSEE, 2007).

These adjustment strategies hint at the danger of relying on place-specific resources to meet the expectations of change in the health system and in ageing communities. As is evident in the next section, one response to this predicament is to look for local opportunities to overcome challenges and, in essence, create a space of resistance to change.

**Evidence of resistance**

Extending the view of *associations* as facilitators of adjustment to change at the local level is evidence of specific responses in Maine et Loire that explicitly challenge and shape the outcomes of changes in the *secteur médico-social* and in ageing communities. Resistance strategies were centred on defending existing services in the community from restructuring imperatives; advocacy for alternative services and service modalities to meet local needs; and refusal of quasi-institutional arrangements and withdrawal of from service provision. Unlike the strategies outlined above, resistance is seen as geared toward ensuring the independence of *associations* locally and sustaining ageing in place as a viable option for older residents that face institutionalization.

The first strategy is an extension of the longstanding (pre-1970s) rationale ‘to fill a gap’ in the *médico-social* services whereby the need to address local services needs remains a central ethos for many *associations*. Indeed, referring to Table 2, almost half (57) of the *associations* indicated ‘to compensate a lack of information, support or services’ as the rationale for their establishment. It is not surprising that initiatives to
defend cut-backs to existing services viewed as locally important came to the forefront (e.g., “We must protect transportation services for people with disabilities”). Examples of such initiatives included garnering support from service users and allied community members to influence health planning decisions at the département and municipalité. For instance, key-informants reported the establishment of informal neighbourhood meetings that provide information about local needs related to ageing (i.e., a “place du village” or village square approach) as an important source of resistance.

The related strategy of advocacy stems from the changing tradition of political involvement within the économie sociale et solidaire, which has a long history of activism on behalf of popular interests but a relatively limited history of direct involvement lobbying government administrations on behalf of specific groups or service sectors. As shown in Table 4, however, both types of resistance to structural change in the secteur médico-social are evident among the strategies employed by the associations. Indicative of the significance of advocacy as a resistance strategy is the range of lobbying targets across the continuum santé médicale and médico-social services, research and vulnerable populations, and the range of activist approaches from association operating within and outside the formal system. Underlying these strategies is recognition of the implications for addressing inequalities in local services, which is encapsulated by a key-informant who explained, “Territorial disparities arise from the energy mobilized by association to set up and develop services. One should not wait for the public authorities to make changes”.

Perhaps most importantly, some associations also highlighted the strategy of refusing to engage with quasi-institutional arrangements and even the ultimate
withdrawal from the *secteur médico-social* altogether. Refusal and withdrawal were considered imperative strategies because of the “risk of being institutionalized” and the “fear of losing local autonomy”. The conflict underlying accepting public funding and contractual obligations is summed up in a key-informant’s story: “We were almost a public service [contractor], but we refused to be given the commission for the service because we wanted to keep our freedom of vision and our initiative”. It was later communicated that the *association* had to withdraw from providing the service in question because the burden was too great. Like their counterparts elsewhere, the *associations* in Maine et Loire are at a crossroads, one that is best captured succinctly by a key-informant who concluded, “We face a choice between entering the game and playing by the new rules, or refusing it and engaging resistance”. Understanding how *associations* are resolving this predicament, however, requires attention to the interdependence among adjustment and resistance strategies.

*Emergence of complexity*

To further extend the view of *associations* as facilitating adjustment to change and creating resistance opportunities for shaping local outcomes, we consider the complexities underlying the multifaceted role of the *économie sociale et solidaire* in the *secteur médico-social*. It is important to acknowledge the contradictory and complementary nature of local dynamics of voluntarism, where the *associations* can be seen as at once operating as a mechanism of adjustment and a space of resistance. Indeed, individual *associations* are seen to undertake adjustment and resistance strategies simultaneously, which highlights the duality embedded in the ‘balancing act’ underway
in the économie sociale et solidaire. For instance, almost 15% (17) of the association were actively procuring government contracts from the secteur médico-social while also leading advocacy initiatives at the level of the région, département and municipalité. As a key-informant noted, “We are both social policy advocates [resistance] and managers of services [adjustment]”. In these situations, it remains unclear which strategic role would prevail and this ambiguity represents an important limitation to the empirical research and the framework adopted to interpret the role of associations in Maine et Loire.

Another major source of complexity is the issue of the scale at which resources and opportunities for adjustment and resistance are manifested. Within the secteur médico-social, centralization remains a historical continuity, whereby resources for local initiatives, such as the coordination and advocacy strategies described above, are most often available from the région. Despite the emphasis on meeting local needs in Maine et Loire, for instance as a key-informant stated, “We are much more reactive than the state in meeting local health needs”, the majority of associations reported stronger administrative and financial relationships with governments agencies in Pays de la Loire (62%) rather than with their public sector partners in the département (45%) or municipalité (26%). The limited reliance on local resources further highlights the complexities and contradictions embedded within the evolving role of associations. Along with more detailed assessment of the specific strategies employed at the local level, careful interpretation of their implementation across the matrix of interactions in the secteur médico-social is required, therefore, to fully understand the potential for success in the face of structural imperatives and ageing related demands.
Discussion

Consistent with the burgeoning literature within health geography’s ‘voluntary turn’, the Maine et Loire case study findings corroborate the important, dynamic and contested role of voluntarism with respect to health and social care. Moreover, the activities of local associations indicate that the existing theorization about the local dynamics voluntarism, and the concepts of adjustment and resistance, and their complexity in particular, are instructive for interpreting local outcomes of change. The evident empirical realities versus theoretical expectations must be considered, however, to fully evaluate what is normative about the evolving role of the économie sociale et solidaire in the secteur médico-social.

It is important first to acknowledge that the ‘provider’ perspective presented above does not address the individual experiences of bénévoles or people who utilize médico-social services, most notably older residents of ageing communities. Nor is the highly gendered nature of voluntarism or the central role of women in the économie sociale et solidaire considered. These limitations, along with the gap in information about local dynamics in metropolitan and remote areas, represent important avenues for future research on health voluntarism in France.

To start, the findings from Maine et Loire highlight the similarities of health voluntarism internationally. The strategies described above demonstrate that the role of the économie sociale et solidaire in supporting older people as they age in place in France is complex and multifaceted. Not only are associations facing the familiar challenge of being caught between the short-term demands of restructuring and the longer-term trends of societal ageing underway elsewhere, they are responding with
many of the same strategies employed in other welfare jurisdictions (e.g., professionalization, activism, withdrawal). The case study, thus, can be viewed as conforming in general to the theoretical expectations that evolving role of voluntarism is a mechanism of adjustment and a space of resistance. The emergent complexity of the consequent actions of associations, whereby they are at once adjusting to and resisting changes, however, raises questions about the extent of convergence both within France and internationally. It is here that we see in-depth attention to the importance of the “place-embeddedness” of local responses to the challenges facing ageing communities (Hanlon et al., 2007: 466) as crucial for further understanding the local dynamics of voluntarism in different contexts.

Expanding on this discussion point, a major source of empirical divergence stems from the distinct historical-geographical context of voluntarism in France. As noted earlier, unlike North America, the UK and other parts of Western Europe, the économie sociale et solidaire has evolved within a political-institutional environment that, despite recent engagement with decentralization, continues to view the national state as responsible for community interests as evident in the traditionally strong involvement of the government in delivering services médicaux de santé. The primacy of the public sector is evident locally at the level of département, which are the target of recent downloading of social insurance responsibilities, such as services for older people, leaving little room for the économie sociale et solidaire to take on additional roles. Despite the growing importance of associations within the secteur médico-social, the legacy of restrictive policies is a major determinant of the emergence of voluntarism in France. As evident in Maine et Loire, however, the ability of associations to act as both a
facilitator of change and a source of resistance suggests the role of the *économie sociale et solidaire* is much more complex and dynamic than envisioned within French policy.

As previously detailed, a major source of complexity underlying the empirical divergence observed in western France is the issue of the scale at which resources and opportunities for voluntarism are manifested (i.e., *région* vs. *département* vs. *municipalité*). While relying on place-specific community-based resources is the theoretical and empirical expectation within other restructuring welfare states, it is clearly not always the case in Maine et Loire. This important divergence is evident in the fact that the *associations* reported stronger relationships with regional agencies rather than with their local partners. Context-specific contingencies such as these raise a critical question about the paradoxical influence of scale in determining how local dynamics of voluntarism are likely to emerge in different geographical settings. In addition to greater attention to ‘place’, an important theoretical adaptation to the framework employed herein, thus, would be to incorporate the growing concern for understanding health and social care as “a complex matrix” within and across scales (Curtis and Riva, in press: 3).

**Concluding comments**

In this paper, we extended the international scope of health voluntarism research by examining the evolving role of the *économie sociale et solidaire* as it relates to the *secteur médico-social* in ageing communities of France. In doing so, we questioned the transferability of prevailing Anglo-American-Antipodean perspectives on voluntarism and evaluated the applicability of a theorization about the local dynamics of voluntary sector activities in particular. The findings from Maine et Loire revealed the potential for
a multifaceted view of économie sociale et solidaire as facilitators of adjustment and sources of resistance to inform understanding of how local associations are responding to the demands of population ageing and health system restructuring. The evident differences in empirical realities versus theoretical expectations also point to the at times paradoxical importance of local resources in explaining how voluntarism works in different health and social care settings. Ultimately, we view the theorization developed by Skinner and Joseph (2007; in press) as transferable albeit partially incomplete, without further attention to unpacking the importance of ‘place’ and ‘scale’ in shaping the local outcomes of change in contemporary welfare systems. The latter represent potentially fruitful adaptations that could enhance the focus on ‘complexity’ required to fully appreciate local dynamics of voluntarism across health and social care contexts.

Overall, the view from western France provided insight into the fundamental question about the ability of prevailing views to inform understanding of health voluntarism internationally. Despite different historical-geographical trajectories, there are issues that transcend the Anglo-American-Antipodean and French perspectives. Both lead to critical questions about (i) the sustainability of the voluntary sector (including the économie sociale et solidaire) in the face of long-term socio-economic demands and the more immediate imperatives of restructuring; (ii) how to best support the voluntary organizations (including associations) in maintaining their precarious positions as at once the mediators of change and sources of resistance to local outcomes; as well as (iii) the very clear need to further debunk assumptions about the potential of voluntarism within health care restructuring policies. Arguably, the answers to these questions rest in the
ability to develop informed policies that take into account the complex and multifaceted ways in which voluntarism is manifest locally.

In closing, we reiterate the call by Milligan (2007) to expand the scope of health geography’s ‘voluntary turn’ within academic and health policy debates, and we extend our own invitation to fulfill the prospect of a more inclusive and global geography of health voluntarism by focusing future research across the continuum of different policy contexts involving the voluntary sector in all its forms including the économie sociale et solidaire. This agenda must focus not only on developing knowledge about health voluntarism in other types of Anglo-American and European welfare states but also in the other contexts of the Global North (such as Eastern Europe) and, perhaps most importantly, in the neglected contexts of the Global South that face similar challenges in meeting the demands of ageing populations.

Acknowledgements

The centre national de la recherche scientifique (CNRS) funded Sébastien Fleuret’s empirical research upon which the paper is based. The original version of the paper was written while Mark Skinner was an Invited Research Professor at Université d’Angers. The authors thank Christine Milligan, Andrew Power and the anonymous reviewers for their contributions. The views expressed are, however, entirely our own.

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Published on-line at: www.sante-pays-de-la-loire.com.


Title: Health geography’s voluntary turn: a view from western France

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Table 1. Local responses to population ageing and health system restructuring

<table>
<thead>
<tr>
<th>Phenomena</th>
<th>Implications</th>
<th>Local responses of associations</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Adjustment</td>
</tr>
<tr>
<td>Population ageing</td>
<td>• Ageing in place</td>
<td>• Maintain older people’s independence</td>
</tr>
<tr>
<td></td>
<td>• Demand for services</td>
<td>• Deliver médico-social services</td>
</tr>
<tr>
<td></td>
<td>• Strain on local communities</td>
<td>• Local partnerships and networks</td>
</tr>
<tr>
<td>Health system restructuring</td>
<td>• New rules and regulations</td>
<td>• Professionalization</td>
</tr>
<tr>
<td></td>
<td>• Contractual imperatives</td>
<td>• Quasi-institutionalization</td>
</tr>
<tr>
<td></td>
<td>• Strain on local associations</td>
<td>• Local coordination</td>
</tr>
</tbody>
</table>
Table 2. Scope of association activities

<table>
<thead>
<tr>
<th>Types of activity</th>
<th>Percent involved (n=115)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative support</td>
<td>51%</td>
</tr>
<tr>
<td>Advocacy</td>
<td>18%</td>
</tr>
<tr>
<td>Charity</td>
<td>11%</td>
</tr>
<tr>
<td>Financial support</td>
<td>6%</td>
</tr>
<tr>
<td>Fundraising</td>
<td>14%</td>
</tr>
<tr>
<td>Home services</td>
<td>18%</td>
</tr>
<tr>
<td>Information</td>
<td>87%</td>
</tr>
<tr>
<td>Legal aid</td>
<td>8%</td>
</tr>
<tr>
<td>Leisure and recreation</td>
<td>17%</td>
</tr>
<tr>
<td>Lobbying</td>
<td>21%</td>
</tr>
<tr>
<td>Medical services</td>
<td>12%</td>
</tr>
<tr>
<td>Moral support</td>
<td>43%</td>
</tr>
<tr>
<td>Research and education</td>
<td>18%</td>
</tr>
<tr>
<td>Shelter and housing</td>
<td>26%</td>
</tr>
<tr>
<td>Social services</td>
<td>26%</td>
</tr>
<tr>
<td>Training and employment</td>
<td>25%</td>
</tr>
<tr>
<td>Other activities</td>
<td>21%</td>
</tr>
</tbody>
</table>
Table 3. Rational for establishing *associations*, pre-1970 to post-1990

<table>
<thead>
<tr>
<th>Rationale</th>
<th>pre-1970 % (N)</th>
<th>1970-1990 % (N)</th>
<th>post-1990 % (N)</th>
<th>un-known % (N)</th>
<th>Total % (N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>To compensate a lack of information, support or services</td>
<td>66.7 (18)</td>
<td>50.0 (16)</td>
<td>36.6 (15)</td>
<td>53.3 (8)</td>
<td>49.6 (57)</td>
</tr>
<tr>
<td>To address an incomplete service</td>
<td>18.5 (5)</td>
<td>21.8 (7)</td>
<td>19.5 (8)</td>
<td>13.3 (2)</td>
<td>19.1 (22)</td>
</tr>
<tr>
<td>To fulfil a system directive</td>
<td>3.7 (1)</td>
<td>9.3 (3)</td>
<td>19.5 (8)</td>
<td>6.7 (1)</td>
<td>11.3 (13)</td>
</tr>
<tr>
<td>To offer an alternative</td>
<td>11.1 (3)</td>
<td>18.8 (6)</td>
<td>21.9 (9)</td>
<td>20.0 (3)</td>
<td>18.3 (21)</td>
</tr>
<tr>
<td>No purpose stated</td>
<td>0.0 (0)</td>
<td>0.0 (0)</td>
<td>2.4 (1)</td>
<td>6.7 (1)</td>
<td>1.7 (2)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100 (27)</strong></td>
<td><strong>100 (32)</strong></td>
<td><strong>100 (41)</strong></td>
<td><strong>100 (15)</strong></td>
<td><strong>100 (115)</strong></td>
</tr>
</tbody>
</table>
Table 4. Association involvement in advocacy

<table>
<thead>
<tr>
<th>Types of advocacy</th>
<th>Percent involved (n=115)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lobbying government</strong></td>
<td></td>
</tr>
<tr>
<td>Implementation or support of medical care</td>
<td>26%</td>
</tr>
<tr>
<td>Implementation or support of non-medical care</td>
<td>17%</td>
</tr>
<tr>
<td>Support for research</td>
<td>11%</td>
</tr>
<tr>
<td>Prevention or information campaigns</td>
<td>39%</td>
</tr>
<tr>
<td>Specific actions towards target populations</td>
<td>63%</td>
</tr>
<tr>
<td>No lobbying at all</td>
<td>27%</td>
</tr>
<tr>
<td><strong>Political activism</strong></td>
<td></td>
</tr>
<tr>
<td>Result of the old tradition of political activism</td>
<td>39%</td>
</tr>
<tr>
<td>The association is in a position of advocacy</td>
<td>15%</td>
</tr>
<tr>
<td>The association is quasi-institutional</td>
<td>20%</td>
</tr>
<tr>
<td>No activism at all</td>
<td>21%</td>
</tr>
</tbody>
</table>
Figure 1. Location of Maine et Loire in the Pays de la Loire region, western France