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CAREGIVERS AND THE STRUGGLE FOR CARE AS ESSENTIAL PUBLIC SERVICE

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Abstract:

Protest against lack of 'service delivery' is a central feature of ordinary working class life in South Africa today. It is striking that much protest focuses on essential material goods and services – housing, water, electricity, sanitation. Less prevalent is protest around the provisions of services which can rest heavily on compassionate care – on the relationship between people. The paper is centrally concerned with compassionate care, collectivised as solidarity, as necessary at the core of any future socialist society. It draws on ongoing engagement between 2010 and 2014 with community healthcare workers from the Eastern and Western Cape in South Africa, and a history of such engagement with domestic workers.

The paper follows discussions amongst community healthcare workers to challenge the rigid socially constructed lines drawn, amongst others, between the unemployed woman, employed domestic worker, and community healthcare worker, arguing that much of what they and others do is similar across the rigid lines, involving the provision of care. It goes into issues they are forced to confront and which surface in discussion and organizing activities: employment and working conditions, registration, recognition, certification. It makes the argument that the worker providing the essential public service of care is subsidising both the employer (government or private) and the state through the provision of cheapened and/or free labour.

The paper draws on 'post-Apartheid' engagement with caregivers to insist their work is an essential public service. It employs the Marxist concepts of commodification and alienation, making the central arguments that capitalism has commodified healthcare but compassion and solidarity are resistant as commodities; that alienation is reflected in the way in which the relationship between people comes to be focused on things. Underlying the struggle for certification, registration and the protective legislation of recognition is the struggle for necessities: security, respect, a living wage, comfortable working conditions, and the necessary resources to have and provide care. In the alienated relations of capitalism, the socially useful and necessary provision of care renders the caregiver denigrated and damaged. The necessary and legitimate struggle for registration and recognition is too easily turned into the legitimation of existing intolerable conditions. In the context of commodification, certification is used by employers to exclude, cheapen and denigrate. At the same

time, the compassionate care which is already being rendered everyday lays the basis for the solidarity central to socialism and necessary at the core of a future public healthcare system.

The paper returns to a vision of alternative which was central to the struggle against Apartheid. At its core was a picture of a different life in which key experiences under apartheid would be buried for all time. The picture of the future was essentially a picture of negation: a world without the worst of everyday life. Increasingly, in popular organization, mobilization and imagination, that vision came to be called by the name of socialism. It needs to be drawn on as a vision in the struggle for caring and sharing.

Introduction

The basis for this paper is that care is a basic social necessity – and as such must be recognised as an essential public service. That means that it must come through government, it must be planned, organised and appropriately resourced to meet need, people must be able to access and receive it where and when they need it. And that means also that someone must do the work and be valued for meeting basic human need. Service delivery protests have been made a feature of the new South Africa. It is striking that in these protests, there is the tendency to focus on material goods and services (housing, water, electricity, sanitation) and a lesser focus on services based on the relationship between people (education, healthcare). Yet it is the combination of these which will be essential to the building of a socialist future and a genuinely humane, caring and sharing society.

There are millions of people involved in doing that work of giving care every day. Many are unemployed. Some of them are employed in a complex set of arrangements crossing the public sector, civil society and the private sector. See Lund (2010); Lund and Budlender (2009). [1]All of this is happening in the context of alienation in healthcare. See Yuill 2005. There is the commodification of services such that the service is either directly commodified, indirectly commodified, or, through the whole set of conditions, happening without the organisation, recognition and support necessary for an essential public service.

The healthcare system is infested with commodification of healthcare. Health Economic Unit (2009). This is self-evidently the case in private healthcare. It is happening in a context of a systematic growth of medical insurance which does not even necessarily involve the provision of any actual health service and care. In the public sector, while the delivery of care might be free at some points of access, even where that happens, there is both the practice and the ethic of commodification running through the system. It can be seen, for example, in the extensive outsourcing, construction, maintenance, supply of medicines and equipment and an elaborate set of public private partnerships.

Studies confirm everyday experience: the community healthcare work must be at the core of any adequately socially useful health service. See Sanders and Reynolds 2011. It is clear that as things are, the community healthcare worker (chcw) is denigrated, not respected, not adequately cared and provided for, not affirmed. Accounts of everyday experience from chcws testify to this, showing the provision of care to be a struggle often leaving the caregiver needed care. A group of chcws put together a composite of their story in a workshop run by Alternative Information Development Centre (AIDC) in 2010. The story has been validated through use in numerous subsequent workshops, including a set of engagements organised by the Industrial Health Group (IHRG) in 2012.

[1] For reasons which will become clear in what follows, I am calling different categories of such workers by the generic of “community healthcare workers”.

The Community Healthcare worker

Nomsa is a community healthcare worker. She started with that work long before she got a job.

There were people who were sick around her. She looked after them. When there was no-one to wash them, she washed them. When there was no-one to cook for them, she brought them food. When there was no one for them to talk to, she sat with them and listened. When they had no money, she helped them to fill in the forms to apply for a grant. Sometimes, she left them with a few Rand even when her pockets were empty. She started to see when people had TB and she learnt where they should go for treatment. She went on some courses, which repeated the knowledge she had already.

Later, she found employment as a community healthcare worker. She started to get some payment for the work she was doing already. First, the payment came from the government. Then it changed and came from the NGO. But the work did not change. Then the NGO said there is no money, and they cut her pay in half. But the work did not get cut in half. There were more people to care for, more people who needed her. With her money cut in half, the work got harder. Sometimes, she had no money for transport so she had to walk, no matter the weather, no matter whether it was dangerous.

People did not come to her for care. She took care to people. Otherwise there would be people without care. And Nomsa could not leave them alone. Before, even when there were no taps, people had some water to wash. Now some of them had taps, but there was no water because their water was cut off. They did not have that little piece of soap. Nomsa had to solve these problems. She knew everything to tell them about clean running water and sanitation and healthy food. She had all that knowledge to share. But still they did not have clean running water or sanitation or money to but the healthy food. So next week when she visited again, there was the same problem again. They filled in forms years ago, and then more forms, but still there was a problem in getting the grant.

Nomsa could see when they needed extra treatment. But all she could do was tell them to go to the clinic – and when they got there, they still had to wait in the queue, because the clinic did not listen to Nomsa. Sometimes the nurses were rude. The doctor did not even know her, the few times he came to the clinic. Now Nomsa heard that the NGO was not going to give them any money any more. But the people still needed care. Without Nomsa, they would have no care.

Inside herself, Nomsa knew that others needed her. She knew she was doing important work. She was proud. But she carried the needs of other people on her back, because no-one else was caring for them. And when the government and the NGO treated her like this, she started to wonder. When she saw the same problems day after day, even with all her work, she started to wonder. When she wanted to help, but could not do everything, she started to wonder. Nomsa was giving care all the time. But she felt sore, because the care was never enough. There was no care coming from other places. She worried all

the time. She was doing useful caring work, but it was making her sick. Healthcare Workers Collective. (2010).

In 2012, a separate IHRG workshop drew together chcws from different parts of South Africa. They identified themselves collectively: "***We are like nurses with nothing****."* IHRG 2012b. Discussion amongst these 'nurses with nothing' is rich with reflections of compassionate concern. They also reflect the search for security and comfort in everyday life, social respect for the value of their work, and the conviction that the work itself should provide them a route out of poverty into comfort and security. There is a set of perceived solutions, offered to and sometimes echoed by chcws. Perhaps the dominant vision is certificated chcws, registering formally and receiving confirmed recognition and consolidated protective legislation, within the healthcare framework, even if at the bottom of the hierarchy.

But are the solutions actually addressing the problem? In what follows, I want to explore these issues, focusing on the issue of certification, and looking at the associated issues of recognition, registration, and employment. These are all drawn on as areas for debate, but more importantly, areas of debate amongst community healthcare workers. My particular concern is to try to open up what I will now call the malignancy of the benign face of commodification as it relates to these issues.

Recognition and registration: Of what from whom?

The 2010 Community Care Workers Forum draft charter reflects the demand of many chcws for recognition. Sometimes it is extended into the demand for formal registration. It is justified by some as the demand for drawing the chcw "into the system".

Although it is a challenge to the rigidities and some of the conventional wisdoms of the healthcare profession, recognising chcws as part of the system is not beyond the system as it is. But by itself, it can – and we should expect it to – simply formalise and replicate the hierarchies which exist. It is a key part of what has happened with domestic workers. The long struggle for recognition under the law has been won. But recognition under the law has served to legitimate some of precisely what the domestic worker has been struggling against. Grossman (2011). Wages are nowhere near a living wage, instead being set at what employers are willing to pay. There is no clear evidence of greater job security but rather a growing incidence of domestic workers using legal channels to contest dismissal and retrenchment - to contest their continuing insecurity. Testimony from domestic workers does not point to a new respect from employers. On the contrary, it points to a response which says they should be grateful because they now have what they deserve.

The fact is that the chcw is in a multi-tiered, severely hierarchical system, and they sit at the bottom. That is how the system is. It is not unlike the argument that the economy should be developed by drawing poor people into economic life. They are drawn in – as poor people. That is how the capitalist economy is. In the healthcare system as it is, the chcw is crucial in that she subsidises the state – by providing a cheap and sometimes free service which the state should be providing; or in the case of the private employer, providing a cheaper service than the employer would have to pay for if she was hiring a certificated 'professional'. This is an essential

component of the actual provision of necessary healthcare to many people. It is not something that happens outside without connection to the healthcare system, but rather a set of realities on which the healthcare system is actually grounded and based.

None of this means that chcws should not be demanding recognition, nor that anyone should not be actively supporting them. It means instead that we should recognise the depth of the demand, not reduce it to formalised technicality. In the demand for recognition is a demand for a more fundamental change in the way in which people doing this essential public service are seen and treated.

Certification: whose demand for what?

Attached to the demand for registration is the demand for certification. Again, it is made by many chcws and sometimes seen as the avenue into registration. It is ordinary and understandable that chcws should demand recognition of skills, training and above each of these, certification. At the same time, instances of discussion amongst chcws question the basis and the underlying meaning of this.

A chcw describes her concern that she would contract HIV through a needle stick injury during a measles campaign. ***"I was not the one to give the injection. They do not let us do that – even when we know how".*** IHRG2012b**.** Separately, I asked others in discussion if they knew how to give the injection. The immediate response was no and a shaking of heads. After a little further discussion this had changed to the statement that they were not allowed to**.**

In a separate discussion, formally designated chcws looked at the work done by domestic workers and sanitation workers. In another discussion, they discussed the work done by an unemployed woman, a nurse, and a chcw. In both discussions, they concluded that these were all healthcare workers. From this perspective, the issue of certification then becomes the recognition of skills, the value of the work, the value of the person doing the work, not the denial of those skills amongst the uncertificated or the unemployed. It becomes an issue of inclusion, not an issue of exclusion. This echoes the ordinary experience of workers in the upsurges of struggle during the 1980s. Your struggle t-shirt was your certificate. It asserted your inclusion. When you saw a different t shirt, you did not try to exclude it. In the spirit of collective solidarity, you welcomed it.

We are in a different context now, in which chcws are far more often offered and look to their own formal educational certification as a way out of problems they encounter. But if we are talking about real solutions, we are talking about the provision of effective, accessible, resourced care, grounded in the values of compassion and human solidarity and recognised for that social value. Accounts from chcws are filled with expressions of compassionate concern in their work. Does the provision of such care rest on certification? Can the provision of such care actually be certificated?

Healthcare is now sold as a service and the healthcare worker is often required to display a particular disposition – loosely speaking, a caring disposition. A human being can genuinely and sincerely feel all sorts of things on the production and offer of money. A human being whose labour is being bought and sold as a service can genuinely and sincerely come to feel compassion for the person/s she cares for. But if compassion is the honest, sincere, heartfelt emotion and disposition of care,

empathy and solidarity between human beings, a person cannot genuinely and sincerely feel compassion just because another is willing or forced to pay. But the practices, procedures, tasks - what may best be called the techniques of compassion - can be commodified. They can be bought and sold as service labour. That service labour has no necessary connection to the disposition and emotion of compassion. There are techniques which can be performed on command – with the emotion being simulated, pretended, lied about, acted, but without genuinely being felt.

If compassion is a heartfelt human emotion, a genuine disposition, not a simulated performance on command, then surely the issue of certification falls away. The issue becomes a continuing underlying one of the way in which human beings relate to each other. The compassion may be appreciated and valued. But the appreciation then forms the basis of the value; the recognition is of the value, and constitutes the certification. And the human being/s who recognise, appreciate and value become the "certifying authority". Where techniques of compassion may be certificated, what is being recognised at best are technical skills, not the human connection between human beings which is given the same name as those technical skills – "care". .

What we see then is the process through which certification becomes central to the reduction of a relationship between human beings to a relationship between things, part of the alienating commodification of capitalism. The outward performance of compassion becomes (part of) a commodity to be bought and sold – and its existence is established not through the exchange between human beings, but by the existence of the certificate. With the certificate there is care; without the certificate there is the absence of care. The higher the certificate level, the 'better' the care. The value and recognition of compassion embodied and carried by a human being is reduced and displaced into the value of a set of techniques, and further reduced and displaced into the value of the certificate. The person receiving the care – involved in any relationship of actual compassion – is removed as the authority whose relationship determines whether there is actual compassion or not. That role is displaced onto the regulatory authority which issues the certificate or does not.

In the alienated context of commodification and the commodified context of alienation, it is not socially useful knowledge and skill embodied in the person, nor sincerity and depth of the compassion, which has the value. That value comes to be placed in the certificate, the thing not the person. The relationship between the chcw and the person for whom she cares is subsumed and turned into a relationship centring on the certificate, the regulating authority, and the employer. The certificate becomes central to the commodification, regardless of actual compassion and concern. The measurement of value depends on whether the thing is issued or not issued. It can and is sometimes bought, sometimes forged; sometimes earned. As long as the price paid is high enough, the forgery good enough, the fraud effective – the thing has the value. Paradoxically, if the fraud is discovered, any actual skill and capacity is thereby defined out of existence, because there is no longer the certificate.

In the context of this commodification, it is as if there is and will be care if there is the certificate, and not care without it. This is not simply a theoretical projection or the imposition of some theoretical concepts. It is a description of the social reality encountered and lived everyday. An unemployed caregiver is not an unemployed

caregiver. She is “not working”. The actual care given by many human beings every day is defined out of existence as care or denigrated and diminished into unskilled care. It becomes care and skilled care not when it is used, given, received, shared, made effective and more effective through the interaction between people, but when it is certificated.

None of this is to deny the value of training, the development of skills, the recognition of those skills. On the contrary, it is to assert that the use value of those skills is in the giving, receiving and sharing in social interaction between people – their effective use to provide care. Encounters with chcws reveal extensive knowledge, through both experience and training, relating to diagnostic screening, appropriate referrals and treatment, amongst others. The problem is in the alienated context of commodification, certification will not affirm that knowledge but actually deny it. The displaced embodiment of all of that in the certificate is an obstacle to and a denial of those skills, their development, and their social value. It is a denial for those who do not have the certificate – as if the skills, their development and their value are not there in the real world. And it is a denial of those who have the certificate – because the skills and the value are detached from them and located in the certificate. It ends up with the caregiver devaluing herself – either because she does not have the certificate, or because she also attributes her value to the certificate, not herself. The crudest and perhaps cruellest version of this is her own sense that there is something wrong and lacking in her because she has a lower level certificate, not a higher level. Because the certificate is literally worth less, the worker as a human being is made to feel worthless.

Recognition from employers through certification

It is not surprising that, given the context of competition and struggle for jobs, better wages and working conditions, it becomes true that chcws themselves want certification. But workers do not need the certificate to establish the use value of what they are doing. It cannot be the case, when they are ready and able to agree that the use value of the unemployed woman’s care may be the same as the use value of the employed woman’s care. In the list of their demands, it can immediately be distinguished from living wages, decent working conditions, job security. In discussion the reason for it appears repeatedly: employers demand a ticket into employment and better wages and conditions.

It is not then about certification as fulfilling a need amongst workers; it is about certification satisfying a demand from employers. For the worker, the need for the certificate is a displaced, mediated need for better wages, conditions, respect. The demand from employers in turn is not based on the use value signified by the certificate, but instead allows them to decide who to include and exclude, and assists them in determining and imposing a price on the labour they are buying. In the very process is embodied the alienation. Human need and the human value of social activity and skill is embodied in the certificate which has been made an additional commodity, accompanying the commodity of labour power. The same reality is there when chcws are asked whether they can give injections – and the answer is no, but the side comment reflects knowledge at a deeper level: “we are not allowed to”. And through the operation of alienation, the worker herself comes to doubt not recognise her own (prior) learning. She does not ’know’ how to give an injection because she does not have the certificate which says she is allowed to. Presenting the

certificate to satisfy the need of the employer becomes the solution to unemployment and a solution also to being placed on the lowest levels of pay. Getting the perceived ticket comes to replace satisfying the underlying needs. Knowing and being able to provide care is displaced onto knowing how to get the certificate which is perceived as alleviation. The worker is forced to be complicit in the reduction of themselves as a human being and their knowledge as socially useful knowledge into a certificate

In the demand for certification is an underlying demand for secure employment, good working and employment conditions, comfortable living conditions, and social respect. It is about recognition as social respect from the employer, the person receiving care, healthworkers, peers, the community – and from the chcw for herself. The registration through certification of chcws has no necessary connection to their real social recognition. It carries no necessary challenge to their denigration, the disrespect for them, their insecurity and uncertainty. It carries no necessary challenge to the market thinking and politics which sustains these realities of their situation. On the contrary, without such direct challenge, registration and certification in themselves can be turned into aspects of the continuation of the denigration, insecurity and poverty which they are claimed to resolve. This is constituting a benign face to what is malignant

Civil society as labour brokers?

There is a complex set of issues and tensions to do with state and civil society at play in the employment of chcws. Workers themselves take up this tension by sometimes categorizing the NGO/NPO as a “labour broker”. Technically, legalistically, they are wrong. Philosophically they may also be wrong. Politically, there are important differences between government, civil society and employer in the capitalist state. But workers are pointing us to the realities of their own lived experience. While there is no profit accruing to the NGO, there are perks, hierarchies and very different income levels. In the employed worker’s experience, the pay may be lower, conditions worse, benefits fewer and employment less secure than direct employment by the state. The general demand for direct employment by the government is essentially about better pay, employment and working conditions. For the rest, the struggle to give care is precisely that – a struggle. The very fact that the same worker may be doing the same work in the same place in the same way facing the same challenges and employed in the public service one week, by the NGO the next, and unemployed the next is testimony to the continuity of experience across the rigid socially constructed lines.

In this context, registration of the chcw as an employee in the healthcare sector ‘interferes’ with her place in civil society and denigrates the service she is actually providing. It can be as if the compassionate care she is giving is “just doing her job”. At the same time, her formal employment is, in some situations, displaced onto civil society, even when the funding is derived from the state. In such instances, employment in civil society, can mean “interference” in the service she is providing for the state and the denigration of that service. It is as if she should not be paid a full wage and should not be regarded as an employee - because she is actually really a volunteer with a stipend for which she should be grateful and to which she is not really entitled.

Where the formal responsibility lies on the government, the chcw is subsidising the

state. Where it lies formally also with the employer, as with health and safety and decent wages to pay for healthcare, the chcw is actually subsidising the employer. In the extreme case, it is 100% subsidy in that the service is being provided free by the unemployed woman. Where no such subsidy is provided by the chcw, there is actually no care. When the responsibility lies with the employer and the state, as formally with occupational diseases and injury at work, the chcw is subsidising both the employer and the government. At the same time, there is a whole world of care taking place which does not reliably fall within existing understandings of the caregiver, such as the actual care given when someone is disabled through a work injury, but not properly recognised as such. In such a case, we are talking about an actual care worker who is not recognised by either the government or the employer, both of whom she is actually subsidising.

The consequence of no care is not a void, but people getting sick when they could be healthier and people dying when they could live. While the circumstances differ, the impact and social meanings are the same. What is happening in effect is that a whole set of issues and responsibilities are being dumped onto the employed chcw and beyond her, onto mainly working-class women who provide the care which is necessary but would otherwise not be provided.

Caring for the caregiver

It has been striking that the story of everyday life and work of the chcw has been a story of the caregiver needing care:

"And sometimes, this work makes us sick. We must look after people who are poor, but we are also poor. We must care for people with TB – but we are exposed to that TB. We must help nurses give injections – but we are facing the danger of needle prick injuries. We must give advice about nutritious food. But we can always afford that food. We must work with that stress. And go home to give more care and smile as if everything is fine. But everything is not fine." IHRG 2012a.

There is a case from Cape Town where we sit, of a grandmother being sent from centre to centre with her sick grandchild on her back to seek help from the health service. She spent considerable time walking because places referred her to others. After trying to get medical care unsuccessfully, she returned home. Her grandchild was dead.

Without that grandmother, the baby would never have survived beyond birth. For a variety of reasons which largely mirror the 'social determinants of health', it is the grandmother who cared for him. The day came that the grandmother needed help. Her care meant that she walked from place to place, looking for that help. But she did not get it. Bio-medical science has developed sufficient precise knowledge to prevent many deaths amongst children from diarrhea. But each year many children in SA and many more in Africa die from diarrhea and other easily preventable diseases. It is sad when people get sick, injured, die. But it is wrong when someone is sick but there is knowledge and medicine that can make them well; when someone is injured when we know how to protect them and prevent the injury. It is wrong when people who give care to sick and injured must struggle to do so, and end up needing care themselves; when people who need care and people who give

care end up blaming each other; blaming themselves. These things are wrong, and preventable, but they are happening all the time.

I have heard people responding to the story to suggest that the solution lies in education. It is a comforting thought for educators. But it is perfectly possible that the grandmother knew that she needed clean water, salt and sugar to deal with the immediate situation. She also knew that she needed more medical care and needed to reach it. But she did not have transport. Transport was in any event not organised to take her from where she was to where she could access medical assistance. But how many places did she pass which had clean water and sugar and salt? How many vehicles passed her as she walked from place to place? This story was widely publicized through the media. But it is an ordinary event in capitalism that a baby who could survive actually dies.

The case was thoroughly investigated by knowledgeable, organisationally independent investigators including senior health professionals. They found that no-one was to blame. In a way, they are right. It would be a mistake to take this death and blame one or another individual. But we cannot leave it like that. It cannot be that this death happens, like many other deaths, and nothing is wrong. Everything is wrong with a system which is infected, diseased and rotten to its core. And all individuals are caught up in that system – in one place or another. But when they made this finding, perhaps they were not thinking about the grandmother, but of those who are employed in the health system. And at the end of the day it is the grandmother who is left with the question: How could I let this baby die? What did I do wrong? Inside herself, it can be she does not know that she cared for the baby. Instead, it can be that she blames herself because the baby died. Certainly all the pressures are there to make it like that for her.

Going beyond? To utopia?

Ruiters et al (2011:9) write: *"Policy choices reflect different ideas about how we should live and what kind of societies went to become."* There are the policy choices made by those with power in the capitalist system. They have led to the multiple crises and barbarism of everyday life. There are also the policy choices made by the other side. They are about where we are going and how we get there, about the transition in struggle from where we are to where we want to be. Medical diagnosis is often about identifying pathology. Instead, it could be about identifying need. In that case, it would be about satisfying needs, not reduced to dealing with a problem: shifting the question from how to deal with a problem to how to satisfy the need. It is a different and better way of seeing that the real problem is needs which are not met, and the real solution must be to meet them. We have needs, many of them socially constructed, displaced and mediated. We have millions of people available and sometimes actually meeting basic human needs. But there is a complete blockage between these things – a set of power relations in the development, allocation, recognition and ownership of resources. And that blockage ends up dumping responsibility for meeting the needs on unrecognised, unsupported working class women who are the main resource, but receive no resourcing – or the needs are not met at all.

So often, politics is being reduced to economics, economics is being reduced to arithmetic and policy debates are about the amount, leaving untouched the power relations which generate the problem, and the relations between people which must determine and constitute the solution. There are signs that we are heading for a situation which repeats much of what has happened with domestic workers – that massive group of workers giving care. It amounts in fact to the formalisation of the marginality of the chcw, what can only become an updated version of dumping on the working class woman. It would be formalising another already existing rung at the bottom of the ladder in which care is a struggle and the caregiver ends up needing care. That is not is not dealing with the problems of commodification or care. It is reorganising them, legitimating through apparent inclusion what is effectively exclusion; legitimating through formal registration and recognition, what is actually ongoing social denigration and disrespect: constructing a more benign face of a malignancy.

We might be far from a society governed and organised on the principle "from each according to their ability, to each according to their needs." It might be romanticism – it is certainly dismissed as romanticism - to imagine a healthcare system based absolutely on need, drawing on disalienated labour, and organised on the value of compassion and the principle of human solidarity. But even in the context of capitalist barbarism of everyday life, there are moments where there is compassionate care, coming from people who may be unemployed, or who are exploited in their work, going to people who may sometimes be ungrateful and demanding – but who also need that care. It is happening each day. We are allowed to glimpse and taste those moments.

Bloch says that "**thinking means venturing beyond"** Quoted in Roberts, (1990): 29
that "**to be human really means to have utopias"** Quoted in Aronson, (1999): 2.
Can we imagine then a utopia in which:

We will just not accept the rigid lines which take three women doing the same work of an essential public service, but dictate that one is not working, one is **just** a domestic worker and the third does not know because she does not have the certificate?

It is extraordinarily stupid and deeply offensive to take someone who is providing a service on which the lives of others depend and say she is not working?

The millions of women whose primary healthcare service is necessary to millions more are as important as the tens of surgeons whose service is necessary to hundreds?

People acquire socially useful skills so that they can be used to provide socially useful services, not certificates which will be abused by employers to exclude others?

'Advanced' means the best possible ways of meeting genuine human needs and 'efficient' means the most effective use of these best possible ways systematically and universally?

Care in everyday life on which millions depend is treated with respect and recognised as an essential public service?

The people doing that are valued and recognised for providing an essential public service?

They have access to the resources that will help them live comfortable lives, provide care better, and meet needs more efficiently?

It is a very limited utopia. But is anything less enough? Good enough? As much as we can imagine?

We are talking then of a different context – one in which social processes and interactions are organised to promote and secure human wellness. As extensive as commodification is, many people needing care cannot pay for it; much of it is provided free; and compassion and concern necessary for the best care cannot simply be commodified. Alongside the crudified commodification by which capitalism appropriates and absorbs every human capacity and every human labour, sometimes tangled up with it, there is also care being exercised without the commodification. Of course it will be necessary to move through struggle in transition to any decent humane society in which provision of care is treated as essential public service. It is important in that transition to recognise as a starting point that the seeds of the future are already laid in the compassionate care which millions of people are already giving everyday in ordinary working class life; to do everything to support and nothing to undermine their collective agency.

Through the above, I have consciously blurred lines between care and healthcare. They are blurred in social reality, but combined in notions of wellness as the best quality of life that we as human beings can produce for ourselves and each other. The collective expression of individual compassion is solidarity. Solidarity between human beings, real humane concern, is the soul of socialism. Compassionate care – the service of human solidarity - cannot be commodified nor can it be produced on order. But it can be promoted, nurtured, supported, encouraged, facilitated, resourced. All of this is about alternatives to commodification, resistance. And all of

this requires organisation, planning and the provision of the necessary resources. The millions of people providing that service in everyday life need to be recognised – in the particular sense of respected and valued because they are providing a necessary public service. The fact is that they are not, so this means a struggle. They are doing this in the context of and despite the numerous obstacles of commodification. They need to be resourced to do it better – as well as possible. Those resources are themselves commodified – so obtaining them also means a struggle. The caregivers need adequate care in the process. The fact is that they are not, so this in turn also means a struggle, an ongoing confrontation with capitalist power.

Commodification of the services which people need for a decent comfortable life is a disease, denying healthcare to millions who could be made healthier, killing millions who could live, forcing costs at each point onto the caregiver. In dealing with public and private sectors of the healthcare system, the differences are so great that it is sometimes as if we are talking about two different systems. It happens also when talking about the formal and the informal economy, the first and the second economy, the north and the south, the developed and the undeveloped world. It is emphasising the difference, but when we do that, we sometimes lose sight of the connections, uneven and combined development where what seems most advanced is there in connections with, because of and at the expense of what is least advanced. But what does this mean? It means that what is most advanced is infested, diseased, culpable. Even with the best that capitalism can offer, giving care all too often leaves the caregiver needing care. The best of capitalist care will be denied to the majority that cannot buy it; it is itself based on alienated labour and far less than the compassionate care that is both necessary and possible amongst human beings. Compassionate care in a spirit of human solidarity will only happen despite and against the realities of capitalist commodification.

This best of capitalist care is a form of ‘advanced’ which is necessarily dehumanized. As a vision, or part of a vision, it carries that infestation with it. We need a different vision of advanced outside and beyond the framework and limitations of what is already diseased, infected, inhumane – what is already a problem, not a solution: that which is best able to draw on human collectivism, sharing, solidarity to develop and use the power necessary to meet human needs. We need to imagine something bigger than changing the arithmetic of commodification: a world in which there is the compassion and caring such that the giving and receiving of care is ordinary. This means a world in which care is shared in a spirit of solidarity – not allocated and bought according to a hierarchical division of labour simply as a set of tasks. The basis of determining necessary services must be actual human needs. The role of doing that must lie in the hands of people needing the service and be controlled by the people working to provide it. This about collectively determining and planning what is socially necessary.

Particularly for those of us who have the luxury of choice, it may be easy to agree with much of the above. But it is also all too easy to agree in conferences, and then accommodate to the pressures of ‘realism’ and the need for ‘pragmatism’ between conferences. There is a long history of critiques and warnings in conferences, made sometimes by people who disregard them outside the conference. We are challenged then to make sure that we do not become complicit in the benign face of

commodification: reproducing the commodification, directly or indirectly, which is at the heart of the problem of the provision of healthcare. This means resolute and unshaking defence of a public sector, appropriately resourced, brought under workers control, and systematically protected from contagious contact with the commodifications of the private sector and public private partnerships.

Beyond that, those of us looking for involvement in this transitional struggle are challenged around vision: Do we have an actual belief – a real vision – that there can really be effective solutions achieved and sustained by ordinary working class people themselves, organised and mobilised behind a vision of their own class agency and confidence in their own capacity to achieve real solutions? Can they really be the agents, drivers, architects and controllers of a system of care which meets human needs? We are sitting here all of us in a new, albeit somewhat aging new South Africa. Some of us never believed it would happen. But it was made to happen, in struggle, against every obstacle. The driving force was those same working class millions, with an over-riding spirit of collectivism and solidarity and a vision of a future in which everything that was worst in everyday life would be negated. It was called by the name of socialism, deepened for some us into communism. We can still call it by those names, with pride and determination about a future, rather than apologetic cautious whispers and nostalgia about a past. Ordinary working class people, through their own organisation and action, emboldened themselves and each other to dream. It happened in South Africa but it reached across the world in probably the largest solidarity movement in human history. They tasted their own power and the power of their own solidarity. And that in turn emboldened them to do what many of us thought was impossible. There is still work to be done to make the impossible possible, work against capitalism. The best of that work will be guided by the richest, deepest, most advanced, humane vision of the collectivised caring and sharing of the future.

“We are proud of what we do. It is a good thing to care for other people.

There are lonely people who have got someone to talk to, because we listen.

There are hungry people who have got something to eat, because we feed them.

There are people with wounds who have their wounds clean because we clean them.

There are people who are taking medication they need because we are there to make sure they do it.

There are people who know more about how to care for themselves and each other, because we show them and help them. …

But at the end of the day? We are not allowed to be satisfied. At the end of the day, we must go home and know that there are people who need many things, but we cannot give them those things. ….

We are doing important work and we are doing it well. But still we say it is not enough. The problems are too big and too many. And we are saying now: A health system which does not solve these problems will never be good enough.” IHRG. 2012a.

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