

# Co-op Elder Care in Canada



## A Call to Action

National Task Force on Co-op Elder Care

Written by John Restakis

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# Table of Contents

<i>Acknowledgements</i> .....	<i>i</i>
<b>Executive Summary</b> .....	<b>iv</b>
<i>A Tragic Tale</i> .....	<i>v</i>
<b>A Profile of Elder Care in Canada</b> .....	<b>1</b>
<i>Seniors Receiving Care</i> .....	<i>1</i>
<i>Characteristics of Seniors Receiving Care</i> .....	<i>1</i>
<i>Community Versus Institutionalize Care</i> .....	<i>1</i>
<i>Informal Caregivers</i> .....	<i>2</i>
<i>What is the overall state of elder care in Canada today?</i> .....	<i>2</i>
<i>Where are the most urgent gaps?</i> .....	<i>3</i>
<i>What policy changes would serve to address unmet elder care needs?</i> .....	<i>3</i>
<i>What is the most useful role that community-based and non-profit models can provide to the field of elder care?</i> .....	<i>4</i>
<b>Co-op Elder Care in Canada</b> .....	<b>4</b>
<i>Research Methodology</i> .....	<i>5</i>
<i>Main Purpose of Elder Care Co-operatives</i> .....	<i>5</i>
<i>Sources of Funding</i> .....	<i>6</i>
<i>Survey Responses - Comparative Advantages &amp; Challenges of the Co-op Model</i> .....	<i>7</i>
<i>Social Co-ops and Elder Care</i> .....	<i>8</i>
<i>Services offered by the Homecare Services Co-operative of Estrie</i> .....	<i>9</i>
<b>Co-op Elder Care - Advantages and Challenges</b> .....	<b>11</b>
<i>Comparative Advantages of the Co-op Model</i> .....	<i>11</i>
<i>Challenges of the Co-op Model</i> .....	<i>14</i>
<b>Co-op Elder Care Models</b> .....	<b>15</b>
<i>Life Lease Co-op</i> .....	<i>15</i>
<i>Equity Co-op</i> .....	<i>16</i>
<i>Cost and Financing</i> .....	<i>17</i>
<i>Foster Care Co-op</i> .....	<i>18</i>
<i>Home Care Co-op</i> .....	<i>20</i>
<i>Co-op Elder Care Models - Summary</i> .....	<i>21</i>
<b>Toward a National Co-op Elder Care Program</b> .....	<b>22</b>
<b>National Task Force on Co-op Elder Care - Recommendations</b> .....	<b>23</b>
<i>Elder Care and Public Policy</i> .....	<i>23</i>
<i>Co-op Sector Recommendations</i> .....	<i>23</i>
<i>Draft Principles for a National Co-op Elder Care Program</i> .....	<i>24</i>

<b>Bibliography .....</b>	<b>25</b>
<b>Appendix A - Co-op Elder Care Survey .....</b>	<b>26</b>
<b>Appendix B - Key Informants .....</b>	<b>27</b>
<b>Appendix C – Elder Care Co-ops .....</b>	<b>28</b>
<b>Appendix D-1 – Survey Responses .....</b>	<b>33</b>
<b>Appendix D-2 – Survey Responses; Co-op Challenges/Obstacles and Advantages/Disadvantages ....</b>	<b>41</b>

## Executive Summary

In June 2006, delegates attending the annual general meeting of the Canadian Co-operative Association were asked to support a resolution calling for the establishment of a National Task Force on Co-op Elder Care. The Task Force was to examine the state of elder care in Canada and to explore the role that the co-op movement could play in addressing what was emerging as a national crisis of care.

This report is the culmination of this work. Over the course of the past two years, The National Task Force on Co-op Elder Care has reviewed a wide range of studies on the state of elder care in Canada. It has consulted with, and heard presentations from, a wide range of organizations and individuals dealing with the problems faced by seniors in this country. Most importantly, the Task Force has examined the ways in which the co-op model is being used to help elders and their families deal with the challenges of aging.

What emerged was a disturbing portrait of governmental neglect and policy chaos with regard to the critical needs being faced daily by seniors in this country. The Task Force learned that there is broad consensus among both practitioners and academics on what the problems are and what is required to address them. It is now clear that unless a concerted effort is launched by a broad coalition of stakeholders, the problems afflicting a growing portion of the Canadian population will not soon be resolved.

What also became clear was that the co-op movement has a unique opportunity to play a lead role in addressing an issue that is of mounting concern to a huge number of Canadians.

In the next 25 years, the population of Canadians aged 65 or older will double. According to the 1996 Statscan census, 75% of Canadians already depend on some form of assistance. Fully 3/4 of a million Canadians (22% of seniors) require intensive care due to a chronic health problem or a physical disability. And increasingly, to be old in Canada means to live out one's final years in poverty.

Over the coming decades these numbers will only increase. But nothing in the way of a comprehensive strategy is being developed to respond to a looming social crisis that sooner or later, will touch every individual and every household.

The combination of a rapidly aging demographic and the reluctance of governments at all levels to launch new social programs spells continuing suffering and neglect for the most vulnerable seniors of today, and even greater hardship down the road for many Canadians now in early middle age.

However, the work of the Task Force also uncovered a ray of hope for the future. Despite the dispiriting state of elder care today, it is also true that in communities across Canada individuals and organizations from all walks of life and from every political persuasion are creating viable, innovative solutions to the needs of seniors. Elder care co-ops are a key component in this effort. In fact, our research has shown that co-ops are now a crucial strategy in providing seniors with the care they need while greatly improving the quality of life they lead.

In addition to outlining the state of elder care and identifying the issues most in need of attention, this report examines a variety of co-op models that respond to the diverse needs of seniors from a wide range of income levels, physical and mental capacities, and social realities. The accomplishments of these co-ops are impressive and often point to creative solutions that are replicable in a wide variety of settings. The high standard of care they provide is reflected in the preference for co-operative models of care among recipients when compared either to state delivered or private, for-profit alternatives.

This should come as no surprise. The maltreatment of seniors in both state-run institutions and for-profit nursing homes is one of the most distressing, and recurring scandals of our society. There are precise reasons for this, but the most important is the absence of direct accountability to consumers or their families for the manner in which elder care is designed and delivered. Too often, the kind of responsive, humane care that all seniors have a right to expect takes a back seat to the imperatives of state bureaucracies on the one hand, or the demand for shareholder profits by commercial enterprises on the other. It is here that co-operative models hold a powerful advantage over either state or private-run systems.

We know what the most urgent problems in elder care are and we know too how these problems can be solved. There is little mystery here. What is lacking is government commitment to addressing an issue that continues to undermine the well being of millions of vulnerable Canadians with corrosive effects on families and communities alike.

To be truly effective, an elder care strategy in Canada requires an innovative blend of government, community, and private resources that together can provide the range of supports that Canada's seniors need to live meaningful, productive lives well into advanced age. This report outlines the kinds of resources that are required and the types of policies that must be enacted for such a strategy to succeed.

The crisis of elder care in Canada is solvable. And the co-op movement holds the keys to an organizational and economic model that can bring tangible benefits to a segment of our society that has been neglected for too long. This is not to say that co-operatives can solve the issues of elder care on their own. Government action is fundamental to any long-term solution. But what co-ops can do is show what is possible when individuals, families, and community organizations come together to solve common problems through the process of co-operation.

During the seventies, the co-op sector worked with government to build one of Canada's most durable social institutions through the creation of the co-op housing movement. Earlier, co-operatives were central to the establishment of a credit union system to serve Canada's most vulnerable communities. That system has now grown to serve millions of Canadians in thousands of communities across the country. And today, the co-op movement in Quebec is helping to build a system of home care co-operatives that stands as a model for the rest of Canada.

The power of the co-op model stems from the willingness of people of good will to work together to solve common problems. It has always done best when the beneficiaries of co-ops have been willing to use their success to help others to further their own aspirations and meet the challenges of the times through the creation of new co-ops suited to new purposes. Canada's seniors are now in need of such help in this time.

There has never been a more opportune time for the co-op movement to mobilize its expertise and its resources to address a social issue of such central concern to Canadians.

## **A Tragic Tale**

Al and Annie Albo had been married for nearly 70 years when Annie, at the age of 91, lay dying with congestive heart failure in the Kootenay Boundary Region Hospital in Trail, BC. Al, 96, was also in the hospital - sick and exhausted from the stress and strain of caring for his wife.

On February 17, Annie was wheeled into her husband's room and told to say goodbye. She was being transferred to a nursing home in Grand Forks 100 miles away. Hospital staff had strapped Annie

to the gurney and so she was not able to embrace her husband in the few moments before they took her away. She died alone two days later. Al died thirteen days after that.

When the newspapers broke the story a wave of outrage swept the province. Angry letters to the editor, negative television coverage, and uproar in the BC Legislature prompted an apology from the Minister of Health and a promise to examine how such a decision could be made. Nurses working at the hospital organized a petition calling for a public inquiry.

According to Margaret Kempston, a registered nurse who worked at the hospital, the Albos' treatment was "horrible and disgusting" but she added that spousal separation "happens all the time".

The final injury was disclosed when a government official confirmed that Trail's single palliative bed was in fact available when Annie Albos was separated from her husband and forced out of the hospital despite the frantic objections of her family. Following an examination by the Deputy Minister of the conditions leading to the decision - an examination in which the senior managers at the Regional Health Authority refused to answer questions - no one was found at fault and no disciplinary action was taken.

This sad story illustrates only too well the tragic consequences and needless suffering caused by a system in crisis. Countless other stories could be told of other seniors and their families who have endured similar indignities in communities across Canada.

But clearly, the story of Annie and Al Albo touched a nerve across the province. And it was not only the empathy and fellow feeling that prompted such anger. It was also the disturbing question that the story raised in the minds of many readers: "could this happen to me?"

Stories documenting the neglect and abuse of seniors have been a staple element in Canada's headlines and news hours for many years. They are familiar and just as shocking today as they were twenty years ago. What receives less attention is the pervasive anxiety and silent struggle that millions of seniors face daily as they contend with the challenges of aging with few supports at home, in their communities, or from government.

But now, with our aging population, the issue of elder care is emerging as one of the most urgent challenges facing Canadian society in the opening decades of the 21<sup>st</sup> century. And over the next 25 years, the population of Canadians aged 65 or over will double.

The crisis that is quietly unfolding around us has its source in a combination of factors that together have created a condition that is new in Canadian society, as it is also in a large number of other western industrialized societies.

The contributing causes are as follows:

- a) The aging demographic of Canadian society;
- b) The imminent retirement and exit from the labour force of the baby boom generation;
- c) The absence of affordable and easily accessible support systems to provide care for elders needing assistance;
- d) The reluctance of government at all levels to plan for and deliver programs for vulnerable elders;
- e) The growing stress on families, friends, NGOs, and the broader civil society to deliver elder care;

- f) The lack of adequate organizational, human, and financial resources for the provision of affordable and accessible elder care outside the public sector.

Together, these factors have led to growing alarm across a broad cross section of stakeholders about the effects on elders, families, and the broader society should the elder care issue continue to be ignored by our elected officials.

This report is part of a larger project to document the state of elder care in Canada and to examine the role that the co-operative movement can play in responding to this issue.

The first part of the report examines, in summary form, the nature of elder care services, the profile of seniors receiving care, and the issues most in need of redress from the perspective of elder care activists and practitioners in the field.

The second part looks at the particular role of co-operatives in providing care to seniors, and presents the findings from a Canada- wide survey of co-ops conducted through the winter of 2006-07.

The third section of the report addresses the comparative advantages and disadvantages of co-op elder care models in comparison to other forms of care and as a response to key issues confronting the care of seniors in Canada. A summary of key co-op elder care models encountered in this project are outlined and assessed.

The final portion of the report addresses the unique role of the co-op movement in providing a response to the eldercare crisis and outlines the actions required to move the sector into a leadership role on this issue.



# A Profile of Elder Care in Canada

## Seniors Receiving Care

According to a major study undertaken by Statistics Canada from the 1996 General Census, the majority (75%) of seniors in Canada receives assistance in some form.

1.6 M receive (47%) received assistance as a consequence of the way their households were organized, 128,000 (4%) received care as a result of a temporary difficult time, while 3/4 of a million Canadian seniors (22%), received care as a result of a long term health problem or physical limitation.

It is this last mentioned group that poses the most serious challenge on the issue of elder care, as it requires the type of care that is most crucial to the well being of those that receive it and unlike other types of assistance is a response to issues of physical or psychological limitations that represent high levels of need.

It is this group we have identified as that for which care is required and to which this report and the broader Co-op Elder Care Project is addressed.

## Characteristics of Seniors Receiving Care

The mean of age of seniors receiving care in Canada is 77 years of age. By contrast, the mean age of those receiving care for a temporary time of difficulty was 73.

Notably, there has been no difference in the proportions of seniors in need of either assistance or care as a result of being urban or rural dwellers. Over 80% of seniors reside in urban centers.

What is interesting however is that seniors living in rural areas are more likely to receive care when their health fails than seniors living in urban centers. This has been attributed to the stronger family and social ties that are still common in rural communities.

## Community Versus Institutionalize Care

While almost 3/4 of a million seniors dwelling in their community received care, only 186,000 received this care in health-care related institutions. The vast majority received care in their homes or in community settings.

In both cases, the majority of seniors receiving care were women with 67% of those receiving care in a community setting being women compared to 73% of those receiving institutionalized care. And very significantly, a high proportion (over 1/3) of those receiving care in institutionalized settings were diagnosed with Alzheimer's or dementia as compared to those living in a community setting.

Informal caregivers provided 90% of household tasks. Government programs, NGOs, provided only 10% of the help for these tasks or caregivers paid by the senior. The majority of the care provided by formal sources was provided to seniors in institutionalized settings.

On the whole, and as might be expected, seniors receiving care in institutionalized settings were on average older and in poorer health than those living in the community, with the biggest factor being the presence of dementia.

Inevitably, seniors currently living in their communities are going to need increasing amounts of care for the remainder of their lives. If the amount of residential care beds remains at current levels or decrease, there may soon be no place for these seniors in institutional settings. As a consequence, increased pressure for the care of these seniors will be felt in the informal and community care sectors.

## **Informal Caregivers**

Today, over 11% of Canadians of all ages are involved in the provision of care for seniors. The majority of these informal caregivers are between the ages of 30 and 60 or over. This represents an important informal labour force,

Women predominate in this role with men playing a more prominent role than was at first understood (61% versus 39%).

Finally, a significant portion of the informal care provided to seniors involves not only the immediate family but includes extended family and friends.

## **The View from the Frontlines**

In the course of the first phase of the research for this project, a number of interviews were conducted with experienced practitioners familiar with the field of elder care in Canada.

The interviews sought to gain insight into the following issues, based on experience in the field.

- a) What is the overall state of elder care in Canada today?
- b) Where are the most urgent gaps?
- c) What policy changes would serve to address unmet elder care needs?
- d) What is the most useful role that community-based and non-profit models can provide to the field of elder care?

The following questions represent a summary of these views.

### **What is the overall state of elder care in Canada today?**

Overall, the impression of elder care in Canada is a system wholly inadequate to address the growing needs of seniors in Canada. The system has been described as patchy, unaffordable, and unresponsive to the real needs of people.

Respondents also noted a lack of comprehensive planning and preparation on the part of governments at all levels to meet the demands of Canada's fastest growing demographic group. This neglect has also been linked by some respondents to those jurisdictions that have been most influenced by neo-liberal policies that consciously limit the role of government in the delivery of public services.

The results of these policies have been that instead of increasing public investment in the systems and infrastructure associated with the rising needs of Canada's seniors, public programs have been cut and services allowed to deteriorate.

In addition, there is the charge that much of the existing money allocated to elder care is being misdirected insofar as non-profit approaches that save public money are being replaced by for-profit models. This often entails a transition from volunteer-run and community based non-profits to remote

bureaucracies that run services for profit, usually under contract to governmental bodies such as regional health authorities.

There was a strong sentiment that elder care should follow the principles of the Canada Health Act and promote widely accessible, portable, and non-profit models of care.

In effect, the current patchwork of services does not in fact constitute a system of elder care in the normal sense. Rather, the current condition of care is one of inadequate and ad hoc services delivering widely variable levels of care that are conditional on users' ability to pay. In the for-profit models, quality of care is often compromised by underpaid and under trained workers (mostly women). Moreover, the older system offered a living wage and benefits, which provided basic support for seniors.

Currently, the number of seniors who have been cut off or are unable to access basic care has increased dramatically.

### **Where are the most urgent gaps?**

At the top of the list for gaps that need to be addressed is the lack of affordable housing for seniors. Waiting lists are growing longer while existing senior's housing is insufficient to meet senior's needs.

There is an urgent need for additional in-home support. Services such as housekeeping, which have been cut from many programs, should be restored as they often make the difference between relative autonomy and dependence for many seniors.

In addition, beds that were closed – both acute care and alternate care - should be re-opened along with the hiring of the requisite skilled staff. Also, training needs to be matched with proper supervision for low skilled workers and volunteers.

It was noted that people who do not need to be in acute care beds should be placed in other types of services. This is currently difficult due to the absence of such alternatives.

The closure of smaller hospitals has had a deep impact on the accessibility of service by seniors as this has exacerbated the continuing problem of transportation in rural and remote areas. Heightened transportation difficulties and the closure of smaller hospitals have also entailed additional costs to seniors in the form of overnight stays, meals, etc.

Finally, the increased costs of pharmaceuticals are a major problem. Some medications are no longer covered and the co-payment system operating in some jurisdictions is an additional burden for the elderly poor.

### **What policy changes would serve to address unmet elder care needs?**

As a basic starting point, practitioners and academics both noted that any new policies should be developed in consultation with local communities and seniors' organizations to ensure that policies respond to the unique needs of individual communities. In this respect, many regional health authorities have shown both a lack of interest or aptitude for this type of community consultation resulting in policies and practices that consistently fail to meet senior's needs.

As one respondent vividly put it "Most policies are like sex manuals written by eunuchs. There is no direct experience by policy makers of the actual conditions that need to be addressed".

Some existing programs need to be more widely known and utilized. This is the case with Shelter Aid for Elderly Renters (SAFER). This valuable program needs to be revised and made more effective and more widely known.

With regard to the key issue of housing, federal housing money is often being funneled at the provincial level through health departments and not used for housing. This needs to change.

Also in the context of housing, there was a strong feeling that CMHC needs to revise the manner in which the agency funds projects so that funding is more flexible and responsive to the conditions of non-profits and other community agencies that serve seniors.

### **What is the most useful role that community-based and non-profit models can provide to the field of elder care?**

The most useful role that non-profits and other community-based models can bring to the elder care issue is higher levels of control for both users and the broader community. This is particularly the case with co-operative models of care.

Secondly, non-profits save money to the public purse not only because of the focus on service as opposed to profit taking, but also because non-profits are GST exempt and often use volunteers which further reduces operating costs.

### **Co-op Elder Care in Canada**

A central part of the research undertaken for this project was to determine the degree to which the co-operative model was currently being used to address elder care issues in Canada and to ascertain what particular kinds of service are being provided by co-ops.

An attempt was also made to determine other factors that help to characterize co-op elder care services including

- sources of funding
- membership base
- key challenges or obstacles to the provision of care
- areas of opportunity, and
- advantages or disadvantages that may pertain to the co-op structure.

It is important to note that while this research has made headway in mapping this area of co-operative activity, this type of research should be considered a work in progress. The number and types of co-operative that are providing this type of service are only now being documented and are increasing in number. The gathering of accurate, current information on the number, type, and quality of services being provided will be an ongoing process.

For instance, while we have identified over one hundred co-ops that provide services to seniors, often it has been difficult to secure reliable contact information and to speak with someone who is in a position to respond to many of our questions. As well, there are certainly some co-operatives that are providing some measure of service to seniors but which are not yet captured by this data.

Nevertheless, an attempt has been made to contact every co-operative for which we have a lead - if only to verify basic information (telephone number, address, etc.).

The survey is in **Appendix A**. The listing of co-ops providing services to seniors is outlined in **Appendix C**. The results of the survey we used to determine additional information on types of service, etc. is attached as **Appendix D**.

## **Research Methodology**

The research project used the following approaches to compile the data in this report:

- a) Personal interviews with key informants
- b) Site visits
- c) Literature reviews
- d) Data collection from regional associations & key stakeholders
- e) Telephone survey

In total, 61 co-operatives providing services to seniors were identified. Of these, we were able to contact and conduct interviews with 19 co-operatives representing almost one third of the total.

## **Main Purpose of Elder Care Co-operatives**

Our survey results indicate that the bulk of services provided to seniors through co-operatives fall into the following main types of activity: housing, assisted living and home care, social and recreational services, health care, and funeral services.

### *a) Housing*

By far the most common service provided by co-ops to seniors is housing. Co-op housing options are of a wide variety and include apartments, townhouses, freestanding dwellings, shared living arrangements, and handicapped units. Some co-ops are actively developing new seniors housing.

The range of housing options that were provided ranged from market housing to subsidized units supported by CMHC. In addition, the housing mix ranged from exclusively or predominantly seniors housing to a mix of seniors, mixed families, and other age groups.

Indeed, a large number of the co-ops we contacted confirmed that the main purpose of the co-op is the provision of housing despite the fact that the co-op often provided additional services to its members.

### *b) Assisted Living and Home Care*

The second most commonly cited services provided to co-op members were assisted living and home care services. This type of service was often integrated into the co-op's housing role.

Typical services include cleaning, lawn care, snow shoveling, shopping, cooking, transportation, counseling, hairdressing, and visiting.

However, in addition to supplementary care services accessed through the housing co-op, a separate group of co-ops focus exclusively on the provision of home care.

This group is growing in importance and, particularly in Quebec, constitutes the most important service complement to the seniors' housing co-ops with respect to elder care services.

The most prevalent organizational structures for these co-ops are worker co-ops whose members are caregivers, and social or multi stakeholder co-ops whose members represent a variety of interests. These include caregivers, employees, users, community members, organizational sponsors or supporters, and volunteers.

#### c) Social and Recreational Services

Social and recreational services comprise a key element in elder care services provided by co-ops, occurring most often within the context of the housing service. These services include social outings, exercise and yoga classes, bible reading classes, gardening, games clubs, and the organization of social events.

#### d) Health Care

*Health care is a key service to seniors provided by Canada's health care co-operatives. While this study does not focus on this group of co-ops as a distinct group, it is important to mention their relevance insofar as health co-ops, although providing health services to the general public, have been cited as particularly relevant to seniors on account of their flexible and innovative response to the particular needs of this age group.<sup>1</sup>*

#### e) Funeral Services

The provision of co-operatively owned funeral services is a new field of service for seniors and their families. The funeral co-op sector has taken hold in Quebec and the Atlantic region and provides yet another important complement to the continuum of care afforded to seniors by co-operatives. Once again, this is a model that most often operates as a separate and distinct field of service from housing on the one hand and health and home care on the other.

### Membership

As might be expected, the membership base of co-operatives providing services to seniors is predominantly composed of seniors who use the co-op's services. In housing co-ops in particular, it appears that the majority of members are people of 55+ years of age. However, many seniors' housing co-ops also include other age groups in their membership including families and in some cases individuals who may have physical disabilities but are not seniors.

The size of the membership base varies greatly from one co-op to another. From a high of nearly 1,000 members of which only 20% are seniors (e.g. Sacree Meadows Housing Co-op) to a minimum of three members of home care co-ops whose members are caregivers (e.g. Care Connections Co-op, BC), the range of membership size in co-ops serving seniors varies widely and is to a large degree dependent on the type of service that is provided. Worker co-ops are smaller in membership whereas housing co-ops are larger. Health Co-ops can have a membership base of many thousands of which seniors are a small minority.

### Sources of Funding

The largest source of funding for co-ops serving seniors comes from member shares and rentals (in senior's housing co-ops). Housing co-ops also receive some amount of subsidy from CHMC. In some cases, the co-ops have been successful at attracting funding from private business.

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<sup>1</sup> Pram and Manga, 1995

Other sources of funding for senior's housing co-ops include the selling of life leases,<sup>2</sup>

Administrative fees for the provision of additional services, and special projects and fundraisers to supplement income.

Start up funding for the development of senior's co-ops is raised from a variety of sources including private donations, churches, foundations, and loans from local credit unions.

For those co-ops that have a health focus, funding is sometimes secured from local health authorities. However, this source varies widely from one jurisdiction to another depending on the particular policies of government health agencies in the region and the history between co-ops and the public health sector.

In the case of home care co-operative outside of Quebec, funding comes primarily from service fees and a provincial program that provides a cost-sharing subsidy to seniors receiving care.

Quebec:

The case of Quebec is unique with respect to the funding of home care co-ops. Since 1997, the Quebec government has provided state support to the development of homecare co-ops by creating two sources of funding for these services.

The first is a grant of up to \$40,000 provided for the creation of a Homecare Social Economy Enterprise (HSEE), and the second is the *Programme d'exonération financière en services à domicile* (PEFSAD), which contributes a portion of home care costs incurred by a recipient of these services.

The combination of these two programs, along with the legislative recognition of solidarity co-ops in 1997, has led to a flourishing of the co-op model for the provision of home care services for seniors (and others) in that province (see Social Co-ops and Elder Care below).

## **Survey Responses - Comparative Advantages & Challenges of the Co-op Model**

It is interesting to note that while survey respondents were positive in their overall assessment of the relative advantages and disadvantages of the co-op structure, it was also true that in some cases respondents were not able to distinguish any particular strengths that the co-op model brings to the delivery of service. In a few instances, there was even confusion on why the co-op form was originally adopted, or even what the co-op model entailed in terms of a unique organizational structure.

The report will enlarge on some of the key points identified below, but the following represents an overview of the findings from those who responded to the survey.

### **Advantages**

In summary, the co-op model was cited as a source of the following advantages from survey respondents:

- Democratic control provides higher levels of involvement and personal empowerment
- The co-op structure provides a safer environment and closer relations among people
- The model encourages interaction between all age groups and between seniors in wheelchairs and others

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<sup>2</sup> Life leases are a means for co-op residents to purchase an interest in perpetuity of the property and their unit. This lease interest is purchased at market value and can be passed on to the resident's estate upon the death of the resident.

- The model makes it more possible for seniors to remain in their own communities
- The model is understood by older members
- Non-profit structure allows more affordable service
- Higher staff retention
- Higher quality of care
- Pride of ownership
- Smaller size can mean more personal levels of care
- Higher levels of community involvement

## Disadvantages

The following are the key comments from survey respondents on disadvantages of the co-op model:

- Some members don't like paying membership fees
- The co-op structure can limit the size of the service to members
- Younger members have less experience with co-ops and are less willing to contribute
- Co-ops require high levels of member involvement and volunteer hours to succeed
- Decision making can be slow

*These results tend to confirm the findings of other studies that have touched on this question. Further comments on the comparative advantages and disadvantages of the co-op model will be discussed at greater length below.*

## Social Co-ops and Elder Care

Social co-ops and Solidarity co-ops have become a key source of care giving to seniors using the co-op structure. In particular, Quebec has seen the rapid growth of solidarity co-ops in which user members share decision-making authority with worker members, and supporter members.

Since 1997, the growth of solidarity co-operatives in Quebec has introduced a major innovation in the organizational make-up of social enterprises serving seniors in the province. Under the HSEE form described above (page 10), there are now 103 enterprises providing home care services in Quebec of which 61 are non-profit organizations and 42 are co-operatives.<sup>3</sup> Most homecare co-ops have adopted the solidarity co-op structure. The balance is consumer co-ops.

To gain a clearer picture of the types of services offered by the home care co-ops, the following is a listing of services offered by Homecare Services Co-operative of Estrie as described in a 2005 pamphlet:

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<sup>3</sup> A key factor in the selection of the co-op model over the non-profit form can be attributed to the presence in the area of a proactive CDR that is available to promote and help set up the co-op model. See J.P. Girard, 2006



## Services offered by the Homecare Services Co-operative of Estrie<sup>4</sup>

Services	Description
Light housekeeping	Dusting, vacuuming, change of bed sheets, etc.
Heavy housekeeping (Spring Cleaning)	Cleaning inside cupboards and closets, washing windows, cleaning furniture
Clothing care	Washing and ironing of clothing
Preparation of meals	Cooking of meals on a daily basis, preparation of frozen meals
Provisions and supplies	Shopping, running errands
Accompaniment during outings	Accompanying people during medical appointments or leisure
Monitoring presence	Keeping company with a person in loss of autonomy so that their natural caregiver can take some time off.

According to data collected over the 2002-2003 period by Jocelyne Chagnon, from the Direction of Co-operatives of the Department of Economic and Regional Development and from the Research (2004), the 103 HSEE generate sales of 91.7 million dollars and employ more than 6000 people, of which half are full-time.

A little more than 5.5 million hours are sold of which 85% represent independent income. In comparison, these incomes represented 79 % over the 2000-2001 period, which indicates a relative decline in government funding as a portion of overall costs.

In Quebec, the HSEE are places allowing for the engagement and the mobilization of citizens in governance, in particular in the decision-making bodies such as the board of directors. Recent work from the Research Laboratory on social practices and policies, carried out in 2002 and 2003 by Yves Vaillancourt, François Aubry and Christian Jetté (2003) and Genevieve Langlois (2004), also made it possible to illustrate the potential for innovation of these organizations, their great sensitivity to the real needs of the population, and overall, their positive impact as regards access to services as well as improvement of working conditions.

Over the 2000-2001/2004-2005 periods, there has also been a sizable increase in the size of HSEEs in Quebec:

Payroll	\$20.3M to \$36.5M
Sales	\$24.4M to \$42.9M
Membership	\$24K to \$38K <sup>5</sup>

Despite this growth however, the financial resources required to sustain the increased levels and costs of providing services have not kept pace. And despite periodic increases by the province to cover the shortfalls between service costs and users' ability to pay, the financial base of many HSEEs remains precarious.

<sup>4</sup> J.P. Girard, Co-operatives Working in Homecare Services in Quebec, 2006

<sup>5</sup> Ibid

Financial instability due to insufficient sources of funding to cover the actual costs of services remains a key weakness of home care co-operatives in Canada and social co-operatives in Italy. And although this weakness cannot be attributed to the co-op form in itself, it remains a vulnerable feature of all social enterprise models that rely on some level of state support for the services they provide, particularly to the most vulnerable users.

Experimentation with the co-op form as a vehicle for the provision of social care has probably progressed further in Italy than in any other western country. The use of social co-ops to care for seniors is one of that sector's most important service areas.

And, similarly to the solidarity co-ops of Quebec, social co-ops in Italy receive a level of state support for their services, mostly in the form of state subsidies that cover the shortfall between the cost of a service and what users pay. As in Quebec, Italian social co-ops are in a constant struggle with the state to secure sufficient financial resources to cover the true costs of the services provided.

*Nevertheless, recent economic analyses reveal an important theoretical basis for the promotion of the co-op form for the provision of social care.*

# Co-op Elder Care - Advantages and Challenges

## Comparative Advantages of the Co-op Model

In reviewing both the available literature and the testimony of care-givers and recipients of services to seniors, the co-op model entails strengths that are intricately woven into the nature of elder care and the conditions within which quality services to seniors are optimized.

### a) Control Rights

The provision of control rights is the most cited benefit that the co-op model provides to members. The power to participate directly in the decision-making affecting the design and delivery of elder care is perceived as essential to what makes the co-op model so attractive to those who have been exposed to it. This is true both in the case of seniors who are members of a housing co-op or caregivers who are members of a worker or solidarity co-op providing services to seniors.

In both cases, control rights mean that members have a greater say in ensuring that services are delivered in a manner that most benefits them as providers or users of the service. In the case of solidarity co-ops and social co-ops that have a multi-stakeholder structure, the content of elder care services is conditioned by the arrangements that are negotiated among the groups forming the membership base of the co-op.

*The presence of control rights also means that the structure allows seniors greater opportunity for social interaction with peers, a greater sense of personal empowerment and control over their environment, and a mechanism to ensure that service quality remains a high priority as well as service affordability.*

For seniors that are contemplating a move from a single family dwelling to a housing development, the desire to maintain a maximum degree of control over one's environment is a paramount issue.

Indeed, control rights were singled out as a key factor contributing to the high levels of satisfaction of members in a study conducted by Kansas University to measure the satisfaction levels of rural seniors now living in senior's co-ops.<sup>6</sup>

Previous research has suggested that residents of cooperatives reap significant advantages because of the participatory nature of cooperative living. Indeed, co-op residents have ownership control of their housing and are responsible for hiring and supervising the management, sitting on the board of directors, and setting operational policies and long-term goals.

Sixty-one percent of respondents said that they were either somewhat or extremely active in the governance of their co-op while only nine percent were not at all active. Eighty-five percent of the respondents said that the co-op gave them a voice in how their housing was run, while 84% said that the co-op provided opportunities to work with others on common goals.

As other research has suggested (e.g., Van Ryzin, 1992), the participatory management structure provided by co-ops may be the key to maintaining older residents' well being and life satisfaction.<sup>7</sup>

The second key factor was the ability of seniors to remain in their community.

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<sup>6</sup> A Look at the Satisfaction of Rural Seniors with Cooperative Housing, Deborah E. Altus & R. Mark Mathews University of Kansas, Cooperative Housing Journal, 1997

<sup>7</sup> *ibid*

Some of the satisfaction of the respondents may be due to the fact that the dwellings are in their home communities. Residents did not have far to move -- only a median of two miles. While rural residents often have to move long distances to find retirement housing, most of the participants in this study were able to remain in communities where they had lived much of their lives. Indeed, 74% of residents said that the ability to remain in their home community influenced them a lot in their decision to move to the co-op.<sup>8</sup>

The Kansas University study is instructive. With the exception of staff facilities and community access, when asked to evaluate their housing situation rural seniors living in housing co-ops rated satisfaction levels higher than comparable scores for seniors living in conventional Senior Apartments. When compared to the apartment sample, the co-op standard scores on the eight subscales of Physical and Architectural Features Checklist (Moos & Lemke, 1992) were above the mean on all of the eight subscales but the two mentioned above. In addition, the co-ops offered more physical amenities, social and recreational aids, prosthetic aids, safety features, and space.<sup>9</sup>

#### *b) Service Quality*

For family members that are concerned about the quality of care that is provided to parents or other relatives, control rights offer some assurance that other interests will not override the interests of those receiving care.

This has been a key factor in attracting a growing number of seniors to the co-op model. It is a direct result of the perception that member control can help ensure that service quality remains a paramount consideration. There is no incentive in a co-op structure to shortchange service quality for considerations like profit maximization.

The same has been found in studies of co-operatives whose members are caregivers. That co-op members have the power to design and deliver services without the need to flow profits to private investors means that service content will better reflect what is in the best interest of caregivers.

This fact has been borne out in a comprehensive study of worker satisfaction levels within the social co-ops of Italy.<sup>10</sup> In this study, the satisfaction levels of co-op workers were higher than workers either in the public service or in private businesses despite that fact that social co-ops on average paid less than the other two alternatives.

The higher levels of satisfaction were attributable to:

- a) A higher degree of worker control over their work
- b) More opportunity for professional development and training
- c) A stronger sense of shared mission with co-workers.
- d) Affordability

Affordability remains a key advantage of senior's housing co-ops when compared to other housing alternatives.

In the Kansas University study, 44% of respondents indicated that living in their co-op had saved them money. In addition, 69% stated that the co-op had a positive impact on their financial situation. No respondents reported that the co-op had adversely affected them financially.

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<sup>8</sup> *ibid*

<sup>9</sup> *ibid*

<sup>10</sup> Borzaga, University of Trentino, 2003

As has been shown in other studies focusing on housing co-ops<sup>11</sup>, the co-op model still delivers the most affordable form of housing when compared to social housing.

The same benefits of the housing co-op model as regards costs of building, property management, and upkeep also apply to senior's co-ops. In addition, some jurisdictions provide a special benefit to the building of seniors' co-ops. This is true in the United States where the Housing and Urban Development Agency (HUD) has special funding earmarked for seniors' co-ops as well as allowing co-op members to receive the same tax benefits as homeowners.<sup>12</sup>

The availability of federal funding under HUD's sections 202, 213, and 221 have also encouraged developers to enter the co-op housing market to serve the seniors age group in part because of the lack of financing from conventional lenders for independent living construction projects.

An additional benefit for developers is the very low turnover rate in senior's co-ops when compared to other forms of accommodation.<sup>13</sup>

### *c) Reduced Health Care Costs*

One of the most compelling arguments for the use of the co-op model is the reduced health care costs and hospitalization rates for seniors living in co-operative settings. The reasons for this outcome are complex and have much to do with the manner in which co-operatives help to nurture a sense of community among seniors and others living in the co-op.

The relationships that are generated by increased interaction among members for purposes of running the co-op are also a source of mutual assistance and social relations that have a direct impact on seniors' sense of personal well-being, on the ability of seniors to live outside of institutional settings and in their own communities, and on the availability of assistance that would otherwise have to be supplied by professional care givers.

In the area of long term care, recent research undertaken in BC<sup>14</sup> and substantiated by prior research in the US and elsewhere, has shown that ownership models have a direct impact on the performance of long-term care facilities with respect to hospitalization rates for residents. For profit facilities resulted in higher hospitalization rates for pneumonia, anemia and dehydration when compared to non-profit facilities attached to a hospital, amalgamated to a regional health authority, or were multi site.

These findings reflect similar results from a study of long term care facilities in Manitoba from the late 1980s<sup>15</sup>, among 59 nursing homes in Maryland<sup>16</sup>, and among Medicaid residents in for profit facilities using data from the National Medical expenditure Survey<sup>17</sup>.

*In brief, the consistency of these results across time, provinces, and countries suggests that residents living in for-profit facilities are more likely to be hospitalized than residents living in non-profit facilities. This fact, combined with the social benefits that flow from the co-op model, provides a compelling case for the utilization of co-operative, non-profit models for the provision of care to seniors.*

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<sup>11</sup>

<sup>12</sup> Independent Seniors Flock to Co-ops, Eli's Senior Housing Report, July 10, 2001

<sup>13</sup> Ibid

<sup>14</sup> Care outcomes in long-term care facilities in British Columbia, Canada: Does ownership matter?,

<sup>15</sup> Shapiro E, Tate RB. Monitoring the outcomes of quality care in nursing homes using administrative data. Can J Aging. 1995; 14:755-768

<sup>16</sup> Zimmerman S, Gruber-Baldini AL, Hebel JR, et al. Nursing home facility risk factors for infection and hospitalization: importance of registered nurse turnover, administration, and social factors. J Am Geriatric Society, 2002; 50: 1987-1995

<sup>17</sup> Specter WD, Selden TM, Cohen JW. The impact of ownership type on nursing home outcomes. Health Econ. 1998; 7: 639-653

## Challenges of the Co-op Model

The challenges of applying a co-operative approach to the provision of services to elders are in many ways reflective of the challenges in using co-op models to provide services in general.

### *a) Lack of Awareness*

On the whole, there is still a general lack of knowledge and understanding of the co-op model both among the general public and among funders and policy makers. The lack of awareness among potential users of elder care services thus leads to a relatively low number of new co-ops for the provision of services to seniors. This is one key challenge of the demand side. The other is a lack of systemic financial and technical supports to encourage seniors and their families to use the model.

On the supply side, the lack of awareness and government support for either senior's housing co-ops or for other kinds of social care for seniors leaves developers of co-op projects scrambling to access sources of financing. With the sole exception of Quebec, the sources of provincial and federal funding that were once available for the development of housing co-ops have disappeared.

### *b) Reluctance to Share Power*

In addition, there exists within some government agencies an apprehension concerning co-operative models in such areas as health care precisely because co-operatives are owned and controlled by their members. For Regional Health Authorities in BC for example, this runs counter to the assumptions of government control over publicly funded services.

### *c) Complexity of the Co-op Development Process*

As in the creation of any type of co-op, there are specific requirements for investment in the development phase of a co-op that are not required in those models that do not rely on similar levels of mutual trust, shared decision making, member participation, and collective risk sharing. The development of a condominium project is a very different proposition than the creation of a co-op in which a sense of shared community is often a driving motivation for members.

### *d) Capital Accumulation and Enterprise Investment*

With the exception of some senior's housing co-ops, co-operatives that provide social care to seniors are very often hampered by their inability to secure enough reserves to invest in the growth of their enterprise. Everything from investment in equipment, advertising, business planning, and the hiring of qualified managerial expertise is handicapped by the lack of ready sources of capital investment in these necessary business costs.

As in other areas of enterprise, both commercial and social, the co-op model must contend with chronic shortages of ready and appropriately structured capital to fuel investment and growth.

### *e) Lack of Managerial Expertise*

A large percentage of co-operatives are initiated by individuals of goodwill who strive to address a social need because there is a market failure for that service. However, the skill sets and motivation that are indispensable for launching a co-op enterprise are very different from those required to place the co-op on a sound business footing and to help it prosper as an enterprise over the long term.

The increasing complexity of social enterprises as they grow can often outstrip the levels of knowledge and expertise that are available within the co-op's membership alone. In this case, co-ops are liable to an inherent weakness that can only be overcome if members recognize that the expertise required to sustain the co-op may have to be sought outside the available skill set of the co-op.

Here again, the development of a co-op elder care sector will depend on the availability of systemic supports for the ongoing training and development of co-op managers. These managers must be equally familiar with the cultural requirements of the co-op model as well as the specialized expertise needed to operate a successful co-operative enterprise in what has quickly become a highly contested market with competitors that are larger, richer, and unhampered by the challenges of running a democratically controlled enterprise.

## **Co-op Elder Care Models**

In its review of existing elder care co-operatives the Task Force identified four models that showed the most promise for addressing a wide range of elder care needs: Life lease co-ops, Equity co-ops, Home Care co-ops, and Foster Care Co-ops.

This section of the report outlines the key characteristics of each of these models and illustrates them with examples that were brought before the Task Force for its review.

### **Life Lease Co-op**

Life lease co-ops are an innovative housing model in which co-op members purchase life leases whose proceeds go toward the development costs of the housing. In this model, the co-op retains ownership of the housing unit. The value of the life leases is returned to the users when they no longer occupy a unit.

Life lease co-ops are often sponsored by a local organization or group of organizations that agree to act as a guarantor(s) for the initial development period of the co-op. Once the co-op is established and the development work is completed, the control of the co-op transfers to the co-op's board of directors.

Typical sponsoring organizations for life-lease co-ops include senior's groups, social service agencies, local credit unions or co-ops, labour organizations, and faith groups.

The great advantage of life-lease co-ops is that they can be built for below market cost since developer profits are excluded. In addition, once life-leases have expired with a given member, the existing unit may be offered to a new leaseholder for below market rates. The co-op may set the lease price to include a surplus that may be allocated toward the provision of additional services to members such as home care and assisted living services, or toward the financing of new housing.

This is a model that is in the financial reach of many seniors since the costs of a life-lease can be met with the profit that is generated when seniors sell their homes. However, it is most appropriate for seniors who are able to live independently or with a moderate amount of assisted living services.

Example:

*McClure Place Foundation Inc. – Saskatoon*

McClure Place Foundation is sponsored by McClure United Church which provided the initial board of directors and supports to launch and manage the project. The McClure Place Foundation is incorporated as a society but operates more like a co-op with residents having representation on the 12- member Board of Directors.

There are currently 130 member/residents in the project. One third of the units (36) are subsidized by the provincial government. In addition, McClure Place does fundraising to provide additional funds to subsidize low-income residents. Regardless of the subsidy, all McClure Place residents receive the same services from the society.

The purchase price of a life lease is now about \$105,000 depending on the housing market. At the time of its development, the cost of a life lease was \$85,000, which was structured as a non-interest bearing loan to the society to cover the costs of building. A key advantage of this model for those seniors who can afford it is that it does not affect the Guaranteed Income Supplement because the life lease is not an interest-bearing loan.

In addition, McClure Place residents pay a monthly rent of \$450 to cover operating costs and the building of a reserve. The monthly rent also provides residents with a part-time nurse practitioner, 24-hour security, fitness equipment, social programs, an activity director, and personal laundry services.

There is currently a long waiting list to get into McClure Place and the model is currently being used in about a dozen similar projects in Saskatoon alone. Life lease co-ops are slowly being developed across Canada with examples being adapted to every region.

## **Equity Co-op**

Equity co-ops are similar to life lease co-ops with the difference that co-op members own the units they occupy. Shares in the equity co-op cover the development costs of the housing and once again, due to the exclusion of developer profits and sales commissions, the equity co-op can develop housing at below market cost.

In some equity co-op models, co-op members are required to take a second mortgage on their unit which is paid off at the time of resale. The proceeds from this second mortgage are allocated toward the construction costs of additional equity co-ops.

Example:

*Amberview Place Housing Co-op, West Vancouver*

Amberview Place Housing Co-operative is a four-storey seniors co-op with 42 units and a number of shared amenities, including a community lounge, meeting room, workshop, laundry and underground parking space for each unit. Of the 42 units, 12 have one bedroom (with 615 square feet), 6 have one bedroom and a den (745-815 square feet) and 24 units are two-bedroom (875-950 square feet).

The project was initiated in the mid-1980s by the District of West Vancouver B.C. The municipality acquired the site and had expected to build non-profit seniors' housing on the site, but applications for provincial funding were turned down because family housing had priority. After considering various options, the municipality decided to request proposals for the private development of a non-



profit and non-subsidized housing project for seniors with some form of co-operative ownership.

The successful proponent of the proposal call, a local architect, assumed a major role in the development of the project. The project was built on the basis of a design-build, turnkey contract. The architect covered the pre-development costs until the construction financing was arranged. The co-op members had some, but only limited, input into the design.

#### How the Co-Operative Works

The municipality leased the land to the co-op for 60 years. The value of the prepaid lease was set at \$775,000, which in 1987 was estimated to be 60% of the freehold value of land. In return for the reduced price, the co-op agreed to maintain the building for non-profit seniors housing.

At the end of this term, the municipality will buy the building from the co-op. The co-op members pay into a sinking fund for that purpose. They pay \$10 per month for the first 14 years, \$15 in years 15-29, \$25 in years 30-44 and \$40 in the following years. The sinking fund is expected to be large enough by the 60th year to pay the 42 members then in residence the market value of the building.

#### Cost and Financing

The development costs of the project were just over \$3 million, including the land costs of \$775,000 and construction costs of \$1.7 million.

Prior to construction, all of the members had to contribute a down payment equal to 25% of the value of their unit and their share of the common amenities. The remaining 75% was due prior to occupancy either in the form of additional member equity contributions or by members assuming a portion of a blanket mortgage on the building.

Based on the strength of the land lease, and the 25% equity from all of the members, Vancity Credit Union provided the construction financing and then the permanent financing for the project. The mortgage for the co-op was initially equivalent to 53% of the total cost of development.

The credit union also arranged mortgages for the individual members when needed for the 75% portion of their equity contribution.

The unit prices upon completion in 1987 ranged from \$56,000 to \$91,000 which were equivalent to between 73% and 83% of market value of comparable units in West Vancouver at that time. According to the terms of the lease, this degree of affordability must be maintained for the subsequent co-op members.

Monthly fees are \$100 to \$164 for maintenance and other common charges, including resident contributions to the sinking fund. Property taxes are paid separately, but are only about \$400 annually.

Members lease the units from the co-operative, and are responsible for its management. The residents hired a property management firm in 1994, but remain involved through committees addressing finance, membership, maintenance, rules and a variety of other aspects.

#### Impact on the Provision of Affordable Housing

The enhanced affordability of this seniors' co-op was achieved principally in two ways:

- a) the equity provided by the members, which represented 25% of the development costs, that reduced the need for construction financing; and
- b) *the land lease made available from the municipality at 60% of market value.*

The affordability of the project is ensured over the long-term by the terms of lease agreement.

### Suitability for Replication

The approach, which combines a favourable land lease with equity contributions from the co-op members, can be readily replicated in other municipalities. It can be used to provide more affordable non-subsidized housing for seniors capable of providing some equity.

### Foster Care Co-op

Foster care co-ops for seniors are a new care model that is well suited to the frail elderly who may not be able to purchase or lease a housing unit. Building on the experience of foster care models for children, foster care co-ops provide living accommodation to seniors in private homes. The members of the co-op are the individual home caregivers.

The co-op provides members with a range of services including nursing and assisted living or home care services for seniors that require them, cleaning services, transportation, recreation and socializing programs, training services, quality control, and oversight. Co-op members benefit from the additional system supports provided by the co-op while seniors living in foster homes can be assured that quality controls and performance measures are enforced by the co-op.

Foster care co-ops may be financed either through individual membership dues from home caregivers or in combination with public subsidies provided to seniors.

Example:

#### *Caring Connections Co-op – Napanee, Ontario*

Caring Connections Co-op is still in the early development stages but the model has been researched and developed through the work of the founder Barb Young, who currently provides foster care services to seniors in her home in Napanee.

The vision of Caring Connections Co-operative is to develop a network of private homes that are highly regarded as preferred living environments for frail elderly people unable to live alone. In addition, the model is committed to giving caring homeowners an opportunity to become valued partners in healthcare.

Caring Connections Co-op provides an umbrella organization for a network of homeowners who provide enhanced room and board services to seniors in need. The co-op focuses on the level of care that falls between independent living and long-term care.

Building on a solid foundation of innovation and clearly defined practices and standards, the co-op seeks to inspire excellence and promote respect, recognition, equality, and service accountability in a team-oriented atmosphere for co-op members.

When fully operational, the co-op will have 64 seniors living in 40 foster care homes.

The co-op's philosophy is that there is no environment more important than a home for caring. Co-op members agree that the best approach to preserving good health is by recognizing each person as an individual. There is a limit of two senior boarders per home, and the possibility for seniors to choose a home-based living arrangement in their preferred location.

For Home Providers, the co-op provides reasonable pay for the daily support services provided - \$27 to \$31 for single-senior homes and \$39.78 to \$45.78 for two senior homes depending on the number of hours of supervision provided. (These rates exclude senior's fees for raw food and accommodation.)

Caring Connections Co-op has developed standardized procedures for both the monitoring and evaluation of care standards provided by co-op members to seniors.

For Frail Seniors, the co-op provides access to private rooms or suites and the right to choose the home that best suits location and lifestyle preferences. Fees are geared-to-income ranging from \$33.00 to \$63.00 per day for seniors whose incomes are \$14,500 to \$24,00+. The balance of the costs for lower income seniors are to be covered through a government subsidy program.

A wide range of services to boarders are available through the system supports provided to Home Providers by the co-op. These include:

- Pet friendly accommodations (in some homes).
- Free cable and telephone hook ups.
- Home-cooked meals (monitored by a dietician).
- Housekeeping and laundry services.
- Transportation to appointments and social activities.
- Planned weekly social activities geared to personal interests.
- Supervision and/or reminders for taking medications (if needed).
- 16-20 hours of "on-call" supervision daily.
- Monthly visits from a registered nurse.
- Assistance with bathing (if requested – externally provided).
- Provisional emergency services up to the maximum allowable limits (24-hour supervision, extra nursing visits, emergency PSW support).
- Quarterly visits from a "wellness monitor" to assess psychological wellness.
- Peace of mind knowing that most services are standardized and home provider performance is monitored and evaluated regularly.
- Peace of mind knowing that those who care for them are also cared for and supported.
- For government, the Foster Care Co-op model offers a wide range of advantages including:
  - Lowering the cost of care for seniors. (Two hours of government provided PSW support through a regional health authority is equivalent to supporting a frail senior in Care Connections for a full day and night. Or, the government's costs for a senior's stay in a hospital for twelve days is more than the cost of supporting the same senior to live in the Caring Connections network for a year).
  - Fewer seniors on waiting lists for long-term care.
  - Fewer seniors being hospitalized and/or visiting emergency rooms.
  - A higher standard of care in an environment that is most conducive to preserving the health and welfare of the frail elderly.

## Home Care Co-op

Home care co-ops are a fast growing care model that has gained impressive strength in Quebec and increasingly in other areas of Canada. The members of a home care co-op may be caregivers or home care consumers, or sometimes both within a multi stakeholder structure.

Home care co-ops may be financed through a combination of private and public funds and in those jurisdictions such as Quebec where provincial programs subsidize home care services home care co-ops have become a major source of services to seniors and other vulnerable populations.

The use of the co-op model for home care services carries a number of important benefits to members. The democratic governance of the co-op ensures that services will respond to the needs of both caregivers and users, while the cost of home care may be kept within affordable limits since most home care co-ops are non-profit, as opposed to private for-profit models.

Example:

### *Care Connection – Mission, BC*

Care Connection is a small worker co-op that was established in 2004 when employees from a private home care provider lost their employment due to downsizing at the company.

At the time, five former workers of the company decided to form a home care co-op when a staff person of the BC Health Employees Union introduced them to the co-op model. The BC Co-operative Association and The BC Health Employees Union helped the co-op get established by providing technical assistance and organizational funding through the Co-op Development Initiative - a federal co-op development program.

After four years of operation, the co-op has three members who provide home care to 97 clients. The members are registered care providers in the area of personal services for the elderly, people with disabilities and children and families. Two co-op members provide direct care services, one runs the office, and one non-member partner does the bookkeeping. All the employees also work in other jobs to supplement the fluctuating work hours of the home care service.

Of the co-op's clients, 29 pay for the co-op's services privately, 66 are funded through the Veterans Independence Program of Veteran Affairs Canada, and two are funded by the Insurance Corporation of BC (ICBC).

In February of 2008, the co-op provided a total of 365 service hours to clients, primarily to Veteran's Affairs Canada clients. A key source of business comes through overflow referrals provided by the agency that currently has the home care contract with the health authority. The agency has developed a good working relationship with the co-op.

In the past, the co-op has tried to gain a service contract with the local provincial health authority, but with little success. The small size of the co-op and its relatively recent entry into the home care market has been a key stumbling block from securing a service contract with the health authority. This, despite an average of over 25 years of home care experience that individual co-op members have accumulated while working in the sector.

This reluctance of regional health authorities to contract with smaller providers is common and has become a major challenge for the development of local, community-based co-op options for health services, including home care, assisted living, and elder care. The health authority was also reluctant to "unbundle" the services it contracted to allow smaller providers to benefit from service bids.

Despite the challenges, the co-op continues to provide its clients with quality service, with a focus on personalized care and the willingness to be flexible and responsive to the individual and changing needs of the individuals they serve.

### Co-op Elder Care Models - Summary

Co-op Model	Service Offered	Membership	Financing	Comments
<b>Life Lease Co-op</b>	Housing/Aging-in-Place	Leaseholders	Private capital; mortgage	Requires local sponsorship; affordable alternative to conventional ownership; can incorporate flexible care.
<b>Equity Co-op</b>	Housing/Aging-in-place	Equity owners	Private capital; mortgage	Below market cost; no developer profits.
<b>Foster Care Co-op</b>	Home support/home care services	Service users; service providers	Private capital; gov't. subsidy	Affordable care in home environment; good alternative to costly building models.
<b>Home Care/ Home support Co-op</b>	Home support/home care services	Home caregivers	Private capital; gov't. subsidy	Usually worker co-ops; maximize control rights of caregivers – some models also include users as members.

## Toward a National Co-op Elder Care Program

The key outcome of the work undertaken by the National Task Force in preparing this report is the conviction that the co-op model has an invaluable role to play in the development of accessible and quality services to seniors and that the co-op movement is in a unique position to launch a major initiative on this issue.

The second conclusion to emerge is that if elder care is to be addressed at the scale required, a national effort combining the leadership and resources of the co-op movement with other stakeholders is required.

*Over the course of the numerous dialogue sessions, presentations, and consultations conducted by the National task Force across the country it became apparent that there was a deep wellspring of support for a national campaign on elder care. What was lacking was a coherent strategy for such an effort and the leadership at a national level to launch it.*

The final portion of this report summarizes the elements of a national co-op elder care program that emerged from the deliberations of the Task Force. These are the principles which the Task Force proposes be applied to the formulation of co-op elder care strategy that would result in the formation of a significant new sector within the co-op movement.

Given the scope of the issue, its relevance to a major segment of the population, and the increasing demand for services, it is not an exaggeration to say that the formation of a co-op elder care program at a national level would rival the significance of the co-op housing sector in its potential for service to Canadians and their communities.

At the level of political action, the Task Force has developed specific recommendations for policy reform. This work could be undertaken independently of the formation of a co-op elder care program, but would obviously be linked with such an effort.

Finally, we have outlined the role that the co-op movement can play both for the development and support of co-op elder care services and for the pursuit of the kind of systemic change that will provide seniors with the level of security and care that is so long overdue.

The proposals set out in this report may appear ambitious. But it is clear that unless action is taken at this level of commitment, the likelihood is not high that the kinds of reforms that are needed will be enacted any time soon.

On a more hopeful note, it is also true that significant advances for the well being of seniors can be secured with relatively simple policy changes to the CPP or the improvement of income support systems to seniors. These are achievable goals, but they need to be tackled at a national level with the support of allies.

If the co-op sector is prepared to take the initial lead, at the level of service delivery and in the political arena, the potential for strategic alliances with like-minded organizations and stakeholders is powerful and places the co-op movement at the leading edge of a movement for reform that touches every household in every community across Canada.

# National Task Force on Co-op Elder Care - Recommendations

## Elder Care and Public Policy

Public policy must be reformed if there is to be any advance on the current state of affairs with respect to elder care in Canada. The National Task Force highlighted the reform of public policy as a top priority in the steps that need to be taken to address this issue.

The Task Force felt strongly that two overriding principles should govern the reform of public policy for seniors in Canada.

1. That no senior should live in poverty.
2. That all seniors have a guaranteed retirement income.

Among the top public policy issues identified are the following:

- a) Secure ministerial responsibility for seniors at both federal and provincial levels.
- b) Improvement of income support systems for seniors (pensions, social security, elder care service subsidies).
- c) Organize an advocacy campaign on homecare in partnership with Quebec home care co-ops.
- d) Creation of housing programs at both federal and provincial levels that directly address seniors' needs (e.g. requirement that a percentage of all new housing be set aside for seniors).
- e) Reform of the CPP to make full pensions more accessible to retired Canadians.
- f) Improvement of compassionate care leave programs.
- g) Explore the use of tax credits to support elder care services (housing, home care, assisted living).

## Co-op Sector Recommendations

The second priority for moving forward on a co-op elder care strategy is the need for concerted co-op sector action and leadership on this issue. The following recommendations are proposed as a framework for co-op sector action.

- a) The co-op sector needs to unite around elder care as a priority social issue at a national level.
- b) The co-op sector should convene and facilitate a national coalition for the advancement of seniors' policy (labour, senior's groups, health groups, social service organizations, faith communities, ethnic organizations).
- c) Existing co-ops and credit unions have a key role to play in supporting co-op elder care projects at a local level.
- d) Elder care should be linked to co-op Corporate Social Responsibility.
- e) A guide/toolkit should be developed for use in community dialogues on co-op elder care.
- f) Specific co-op elder care models should be researched and promoted for replication across Canada.
- g) A pan-Canadian support system to develop and support elder care co-ops should be developed with the direct involvement of key Canadian co-ops (financing, technical support, possible foundation and pension plan support, etc.).

- h) An entity should be developed to spearhead and co-ordinate a co-op elder care strategy at a national level.
- i) Co-op sector resources should be developed to support elder care co-ops (home care insurance policies, life-lease mortgages, etc.).

### **Draft Principles for a National Co-op Elder Care Program**

As in the past, the co-op movement in Canada has a unique opportunity to apply the co-op model at a systemic level to an issue of central concern to Canadians. Like co-op housing, elder care co-ops can flourish if certain principles and supports are put in place.

1. The co-op model(s) generated by the program must be locally owned and responsive to local needs and conditions.
2. The program should be flexible.
3. The program should address different needs of different users (low income/middle income, rural/urban, high need/low need).
4. The program should be linked to existing co-op structures (housing co-ops, funeral co-ops, health care co-ops, and social and solidarity co-ops).
5. The development of the program should be accompanied by advocacy for supportive legislation and public policy.
6. The program should seek and accommodate some degree of supportive government funding.
7. The co-op model(s) used by the program should be clear, easy to understand, replicable, and accessible to a broad range of users.
8. The program should anticipate and be responsive to future needs and trends.
9. The program should integrate both a national and a local dimension.



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## **Appendix A - Co-op Elder Care Survey**

### **Purpose:**

- a) To ascertain the degree to which co-operatives in Canada are providing elder care services
- b) To ascertain the types of elder care services co-operatives currently provide
- c) To confirm the source of funding for these services
- d) To identify the key challenges co-operatives face in providing elder care services
- e) To identify key opportunities for use of the co-op model in the provision of elder care.

### **Survey Outline:**

1. Introduce yourself as a representative of BCCA and outline the purpose of the survey within the context of the Co-op Elder Care Project.
2. Confirm the address and contact info of the co-op and correct if necessary.
3. Confirm the main purpose of the co-op and its key areas of service, including its membership base.
4. Do you provide services to seniors through your co-op? If yes, what types of services?
5. What is the source of funding for your co-op's elder care services?
6. What would you say are the key challenges or obstacles the co-op faces in providing services to seniors?
7. What are the areas of opportunity that you see for co-ops for the provision of services to seniors?
8. In what way do you feel that the co-op model has advantages over other models for the provision of quality elder care?
9. Are there other co-ops in your region that provide eldercare services. If so, does your co-op work with them? Is there a benefit to your co-op from networking and if so, what?
10. How was your co-op started?

## **Appendix B - Key Informants**

Joan Reichardt, Community First Health Care Co-operative, Nelson

Val MacDonald, Senior's Housing Information Network, Vancouver

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