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Health and Social Care Committee

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

Meeting Venue:
Committee Room 1 - Senedd

Meeting date:
8 February 2012

Meeting time:
09:15

For further information please contact:

Llinos Dafydd
Committee Clerk
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Agenda

Private meeting

The Committee resolved to meet in private at their meeting on 2 February 2012 for items 1 & 2 of this meeting.

1. Introductions, apologies and substitutions

2. Inquiry into the contribution of community pharmacy to health services in Wales - Consideration of key issues (09.15 - 09.35)

Public session

3. Forward Work Programme - Further discussion on 'one-off' evidence sessions (09.35 - 09.45) (Pages 1 - 8)

HSC(4)-05-12 paper 1

4. Inquiry into Residential Care for Older People - Discussion with Jean-Pierre Girard in relation to written evidence commissioned by Wales Progressive Co-operators (09.45 - 10.30) (Pages 9 - 41)

HSC(4)-05-12 paper 2a - consultation response
HSC(4)-05-12 paper 2b - additional information

Jean-Pierre Girard, specialist in the development and management of co-operative, non-profit and mutual organisations (nominated by the Wales Progressive Co-operators)

5. Papers to note (Pages 42 - 43)

Minutes of the meeting held on 25 January

HSC(4)-03-12 minutes

Health and Social Care Committee

HSC(4)-05-12 paper 1

Forward work programme – Further discussion on 'one-off' evidence sessions

To: Health and Social Care Committee

From: Committee Service

Meeting date: 8 February 2012

Purpose

1. To discuss and agree how to use the fourth day available to the Health and Social Care Committee between now and the summer recess for a one-off evidence session.

Background

2. At its meeting on 2 February, the Committee discussed topics for four 'one-off' evidence sessions for the spring and summer terms.

3. The Committee agreed to pursue one-day inquiries in relation to the following topics:
   - wheelchair waiting times in Wales: follow-up work on the recommendations made by the Third Assembly's Health, Wellbeing and Local Government Committee's Report on Wheelchair Services in Wales;
   - venous thrombo-embolism prevention; and
   - reduced fetal movements and still births in Wales.

4. The Committee also agreed:
   - to re-visit the topic for their fourth session at a later date, deciding between co-responder services, access to medicines or orthopaedic waiting times;
   - to await the report of the House of Commons Welsh Affairs Committee's on-going inquiry into post-traumatic stress disorder before undertaking work on this topic; and
   - that the subject of health inequalities would require longer than one day for consideration and, as such, should be placed on the list of possible future inquiry topics.

Options

5. The Committee may wish to select one of the following three topics for its fourth available day:
   - co-responder services;
   - access to medicines;
   - orthopaedic waiting times.

   Information on each of these is attached at Annex A to this paper.

6. Alternatively, the Committee may wish to retain a gap in the programme to allow sufficient flexibility to respond to any emerging issues and / or future legislation.

Action

7. The Committee is invited to consider and agree how it wishes to use the fourth day available in its forward work programme between now and the summer recess.

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

Annex A

Health and Social Care Committee

Forward work programme

Date of session: **2 February 2012**

Introduction

The purpose of this paper is to provide relevant information in support of the Health and Social Care Committee Members' decisions in scoping future short inquiries.

This briefing has been produced by the Research Service for use by the Health and Social Care Committee.

For further information, contact Victoria Paris in the Research Service
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Research Service

Cynulliad Cenedlaethol Cymru National Assembly for Wales

Committee Remit

The Health and Social Care Committee's role is to consider expenditure, administration, policy and legislative matters within its remit. The main areas of ministerial responsibility falling within the Committee's remit are listed below.

National Health Service

Social care

Mental health services

Public health and health protection

Health improvement

Carers

Social services activities of local authorities

Aids, adaptations and support at home

Independent living

Care in the community

The Older People's Commissioner for Wales

Food safety

Prison Service health service

Regulation of residential, domiciliary, adult placements

Research and development in health and social care

Relevant EU policy matters

So far this term, the Committee has undertaken the following pieces of work:

Inquiries

Inquiry focused on the provision of **stroke risk reduction services** and the effectiveness of Welsh Government policies in addressing any weaknesses in these services – completed December 2011

One-off evidence session on the public health implications of inadequate **public toilet facilities** – ongoing

Inquiry into the effectiveness of the Community Pharmacy contract in enhancing the contribution of **community pharmacy** to health and wellbeing services – ongoing

Inquiry the provision of **residential care in Wales** and the ways in which it can meet the current and future needs of older people – ongoing

Legislation

Members will be aware of the following legislative developments:

The ***Food Hygiene Rating (Wales) Bill***: the draft Bill and consultation paper were published by the Welsh Government on 14 December 2011. The consultation period ends on 7 March 2012.

The ***Organ Donation (Wales) Bill***: the White paper was published by the Welsh Government on 8 November 2011. The consultation period ends on 31 January 2012.

The ***Social Services (Wales) Bill***: a public consultation will be launched in March 2012, with a view to introducing the Bill into the National Assembly for Wales in October 2012. Regulations and a Code of Practice for Social Services will be developed once the Bill has received Royal Assent.

The ***Public Health (Wales) Bill***: a consultation is due to be published in 2012.

Potential inquiries: any of the following subjects could provide a timely inquiry for the Committee.

Title	Subject
Health inequalities	In March 2011 the Equality and Human Rights Commission published the report ***How fair is Wales?*** which called for a reduction in health inequalities between socio-economic groups, especially those affecting older and younger men. The ***Programme for Government 2011-2016*** states the Welsh Government will implement the actions contained within its technical working paper ***Fairer Health Outcomes for All*** in order to prevent poor health and reduce health inequalities. **The Committee may wish to consider the progress being made on implementing the actions contained within the health strategic action plans and how this is reducing health inequalities between socio-economic groups in Wales.**
Wheelchair waiting times in Wales	In May 2010 the former Health, Wellbeing and Local Government Committee published a ***Report on Wheelchair Services in Wales***. The inquiry was undertaken as a result of criticism of the effectiveness of these services to meet service users' needs, with waiting times for assessment and provision of particular concern. The Welsh Government's *All Wales Posture and Mobility Review - Phase 2* was published in October 2010 and following this an additional £2.2m of recurrent funding was allocated in the draft budget to help implement the Review's findings and recommendations, and in particular to ensure waiting times standards contained within the Children and Young People's National Service Framework are delivered by March 2012.[1] In March 2011 the All Wales Posture and Mobility Service Partnership Board, as an Advisory Group to the Welsh Health Specialised Services Committee (WHSSC), was established to implement the Review's recommendations. **The Committee may wish to review the progress being made on implementing the recommendations contained within the former Health, Wellbeing and Local Government Committee report in relation to wheelchair waiting times, recommendations contained within the *All Wales Posture and Mobility Review - Phase 2* report, and progress being made on delivering the waiting times standard by March 2012.**

[1] Welsh Health Specialised Services Committee, Joint Committee, ***All Wales Posture and Mobility Service, Agenda Item 15***, 29 November 2011 [accessed 23 January 2012]

Co-responder	Concerns have been raised that co-responders are not being utilised effectively. **The Committee may wish to investigate the use of co-responder services across Wales; the type of call-outs currently being dealt with by co-responders; clinical efficacy; potential cost savings; and response target times.**
Venous Thrombo-embolism prevention	Pulmonary embolism following deep vein thrombosis in hospitalised patients causes between 25,000 and 32,000 deaths in the UK every year.[2] In February 2005 the House of Commons Health Committee published a report on *The Prevention of Venous Thromboembolism in Hospitalised Patients*. In January 2010 the National Institute for Health and Clinical Excellence (NICE) published clinical guidelines on *CG92 - Reducing the risk of venous thromboembolism (deep vein thrombosis and pulmonary embolism) in patients admitted to hospital*. The guidance offers best practice advice on reducing the risk of venous thromboembolism (VTE) in patients admitted to hospital. **The Committee may wish to explore the implementation of the NICE guidance across Wales and the work of 1000 Lives Plus in preventing VTE.**
Reduced fetal movements	In March 2008 NICE published clinical guidance on *Antenatal care: routine care for the healthy pregnant woman*. In February 2011 the Royal College of Obstetricians and Gynaecologists (RCOG) published new advice for clinicians on the management of women with *Reduced Fetal Movements* (RFM) during pregnancy, providing recommendations as to how women presenting RFM in both the community and hospital settings should be managed. **The Committee may wish to investigate the implementation of the NICE and RCOG guidance across Wales and the services pregnant women are receiving with regard to RFM in both the community and hospital settings.**
Post-Traumatic Stress Disorder (PTSD)	In February 2011 the former Health, Wellbeing and Local Government Committee published its *Report on Post-Traumatic Stress Disorder Treatment for Services Veterans.* In 2010 the Welsh Government had begun to roll out a specialist mental health and wellbeing service for veterans following a pilot scheme in Cardiff and the Vale. The report made recommendations on improving data collection on the incidence of PTSD; raising awareness of PTSD among veterans and their families; improving access to substance misuse services for veterans with PTSD; and the

[2] House of Commons, Health Committee, HC99, *The Prevention of Venous Thromboembolism in Hospitalised Patients*, February 2005 [accessed 23 January 2012]

	transfer of medical history from the armed services to GP practices. Healthcare Inspectorate Wales (HIW) is conducting a review of the adequacy, availability and accessibility of NHS provision for Armed Forces personnel, their families and veterans in Wales. The Review started on Friday 9 December 2011 and will run until 20 February 2012. A report of the findings will be made to Welsh Ministers in April 2012. The Welsh Affairs Committee (WAC) has announced they are undertaking an inquiry into the Support for Armed Forces Veterans in Wales, which will examine cross-border co-ordination as it affects veterans, and the level of co-ordination between the Ministry of Defence, the Wales Office and the Welsh Government. The deadline for written evidence submissions was 18 November 2011 and it is likely the oral evidence gathering sessions will begin in February 2012. **The Committee may wish to examine the progress being made on implementing the recommendations contained within the former Health, Wellbeing and Local Government Committee report on PTSD and, once completed, the reports and recommendations made by HIW and WAC in relation to PTSD.**
Orthopaedic waiting times	In December 2010, the then Minister for Health and Social Services, Edwina Hart AM, issued a statement on waiting times in relation to orthopaedic services. The Minister stated that work would commence on developing plans to increase orthopaedic capacity, and in March 2011 the Welsh Government announced the investment of an additional £65 million over the next three years to drive down waiting times for orthopaedic services in Wales. In July 2011 the Minister for Health and Social Services, Lesley Griffiths AM, stated the additional funding is being used to develop sustainable solutions to increase capacity and reduce demand for orthopaedic services and that, by March 2012, no-one should be waiting longer than 36 weeks. Plans are in place to increase capacity, including the building of two modular theatres in North Wales, employing additional consultants. Across South Wales, LHBs are exploring innovative ways to reduce demand across the Region. **The Committee may wish to review LHBs' achievement of the waiting time targets; the utilisation of the additional funding provided by the Welsh Government; and the effectiveness of the plans for increasing capacity and reducing demand.**

Health and Social Care Committee

HSC(4)-05-12 paper 2a

Inquiry into residential care for older people - Supplementary evidence commissioned by Wales Progressive Co-operators from Jean-Pierre Girard

Co-operative models of care for older people

Learning from the Quebec experience 1997-2012

Summary of a report prepared by

Jean-Pierre Girard M.A. B.Sc. B.A.

January 2012

The co-operative membership
Cymru/Wales

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Domestic Help Social Economy Enterprises (DHSEEs) in Quebec

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iii. Funding
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i. Background to establishment of DHSEEs in Quebec
ii. Additional comments on questions M. Girard was asked to address, mainly based on the HSCC Inquiry terms of reference
iii. Glossary

……………………

Foreword

A thorough understanding of co-operati*on*, its ethics and commitment to reciprocity and democratic participation, and acceptance of its world-wide principles, is surely necessary, especially when in contrast to Quebec, we do not have legal recognition of UK multi-stakeholder co-operatives.

In March 2010 we organised, through WCVA, a study day, funded by The Co-operative Cymru/Wales, to provide foundations for the redevelopment in Wales of just such an understanding of co-operation.

To follow this, as our contribution to the celebration of the United Nations Year of Co-operatives 2012, we have commissioned this report and arranged a visit to Wales of the author, Jean-Pierre Girard, who will be speaking at a seminar, to be hosted by Rosemary Butler, AM, at Ty Hywel, on February 7th 2012. We hope this will help to give impetus to care co-operatives in Wales.

M Girard has been intimately involved with home care co-operatives in Quebec since 1997. He has been a Commissioner and since 2001 a member of the board of the International Health Co-operative Organization (north America region); and a frequent contributor to OECD publications related to social enterprises. He has considerable knowledge of the incentives and decentralised resources for local co-operative development in Quebec.

In the hope that this could translate into positive action in Wales, a two day visit has been organised in a co-operative fashion through voluntary action by the Wales Progressive Co-operators and Cartrefi Cymru: funded with a grant from The Co-operative Cymru/Wales, Public Health Alliance Cymru and the Welsh Food Alliance.

In a context of a rapidly aging population and significantly growing elder needs, we hope to provide a spark to assist in the development of new forms of care in addition to state provision, following modern lines of involvement and participation but building on methods of reciprocity and co-operation that have developed over the past 160 years.

We also see through co-operation a great potential to improve the status and terms and conditions of employment of a predominantly feminised home care workforce. By their very nature, multi-stakeholder co-operatives offer a real opportunity to address this accountability gap.

We hope that Wales can provide a beacon to other parts of the UK in developing genuine stakeholder co-operatives and in so doing help to avert any drift towards less accountable mutuals, which could mask the privatisation of public services.

David Smith, Wales Progressive Co-operators
Adrian Roper, Chief Executive, Cartrefi Cymru

January 2012

Domestic Help Social Economy Enterprises (DHSEEs) in Quebec

1. Establishment of - DHSEEs

Two socio-economic summits were held in Quebec in 1996 bringing together representatives of the provincial government, management, labour and civil society. The women's movement played a significant role in promoting the idea of the government's funding social infrastructure to tackle major unfulfilled social needs, particularly in relation to home care services. This was conceived as a way not only of responding to an unmet need but also as a way of creating a significant number of jobs – predominantly for women. A working group was established to consider this proposal and recommended the establishment of social economy enterprises to deliver housekeeping services to individuals with physical and cognitive disabilities. It was further agreed that these enterprises should avoid duplicating services offered by the public sector. Four main objectives were identified:

(1) To provide quality domestic help services
(2) To create quality jobs (especially for women)
(3) To combat undeclared work (moonlighting)
(4) To avoid substitution of public sector jobs

These recommendations were agreed and a network of DHSEEs was established in each of Quebec's 17 regions – a total of over 100 across the province. A selection process was established to provide official recognition of these DHSEEs. Some were established by recognising existing services providers, others by an agreed merger of existing charitable organisations whilst others were newly established organisations deemed to have the capability of fulfilling the tasks outlined.

Initially 104 DHSEEs were recognised. Of these, 57 were Non-Profit Associations (NPAs) and 47 were Co-operatives – see Appendix iii. for details of the difference between these two kinds of organisation. Most of the co-operatives opted for the multi-stakeholder rather than the single member category – again see Appendix iii.

2. Services to be provided

The main tasks identified for the DHSEEs in 1996 were:

(1) Housework – both light and heavy
(2) Laundry & ironing
(3) Errands and purchase of groceries
(4) Preparation of non-diet meals
(5) Light outdoor maintenance work.

Over time, services have been extended to include:

(6) Personal hygiene services such as waking, bathing, dressing and assistance with eating
(7) Civic assistance such as help in venturing outside the home, form filling etc.
(8) Family relief such as sitting with people to allow free time for carers and longer periods of respite care.

Data for DHSEE activity in 2007 shows that at that time there were 101 enterprises (54 NPAs and 47 Co-ops) which between them provided 5.1 million hours of services to over 76,000 people. They had sales close to $106 million and employed 6,000 staff (nearly 90% of whom were women).

3. Funding

The Quebec Government adopted a scheme known as "Financial Assistance for Domestic Help Services". This states "Persons using domestic help services provided by a Domestic Help Social Economy business that has been accredited for program purposes may receive financial assistance applicable against the hourly rate the business charges. There are two types of financial assistance:

- Basic financial assistance of $4 for each hour of services rendered is granted to any eligible person regardless of family income

- Variable financial assistance of $0.55 to $8.25 for each hour of service rendered may be granted over and above the basic financial assistance, and is determined on the basis of the eligible person's family income and situation,

The person pays only the difference between the rate charged by the business and the financial assistance granted".

There is also a tax-credit for home support for seniors for persons over 70 "so that they will not have to move to an establishment in the public health and social services network or so that they can delay having to make such a move".

Most of the income of individual DHSEEs comes from the charges made to service users, but this is backed up by a provincial government grant representing between 15% and 20% of their total revenue.

4. Promotion of DHSEEs

A Federation of DHSEE co-ops was formed at the outset in 1996 offering a forum for exchanging views and providing training and advice for board members, advice on human resource issues, implementation of common management software, setting and monitoring quality standards, business development support, legal advice etc. A similar organisation was established

for NPAs, but that has tended not to be as effective as the Co-op Federation and has since fragmented.

New enterprises also benefit from pump-priming funds including start-up grants and funds from the anti-poverty programme, which are used to subsidise employees' salaries.

For over 20 years the provincial government has also funded a network of 11 Regional Development Co-operatives (RDCs) - covering all 17 regions of the province. These RDCs hire specialists (some 60 in all) to support the grass-roots development of new co-operatives by networking, provision of business and legal advice etc. The RDCs receive additional grants for each new co-op established and for jobs that are either saved or created.

APPENDICES

1. Background in Quebec

Provincial governments are responsible for health and social services in Canada and provision across the country varies considerably. With a population of some 8 million, Quebec is the second largest province in Canada. Some 80% are French speaking whereas the vast majority are English speaking in other provinces.

Prior to 1996, home care for the elderly in Quebec was provided almost entirely by voluntary organisations, which depended largely on volunteer support, for profit organisations (focussing mainly on fee-paying service users whom they regard as profitable customers) and three emerging co-ops. There was a considerable amount of moonlighting (undeclared work) and many unmet needs in the population.

Over the last 100 years, although only three co-ops were providing an element of social care, co-ops as well as private for profit enterprises and public organisations have been a significant feature of the province's economy. Co-ops include large-scale organisations in banking, financial services and agri-food. Co-operatives are also engaged in production (eg forestry and para-medical products) and in retail, housing and funeral services. Legal recognition was given to multi-stakeholder co-ops (see Appendix iii) in 1997 and this has led to the extension of co-operative enterprises in child care, health and social care, tourism, outdoor activities, fair trade, the environment etc.

2. Additional Comments on Questions Jean Pierre Girard was asked to address

How do people gain entry to co-operative models of Residential Care in Quebec? The service is available to all**.**

Do people become members before they need care? About 5%-10% do – mostly family members of households where a service is already provided. But this is not necessary. On receiving a service most recipients become co-op members as it increases their involvement in decision-making regarding the care provided.

Is there a members "waiting list" or are they referred to a co-operative by professionals of the state following an assessment of need? Recipients of care may be referred by a professional from a public service but many self-refer. There is usually little delay in instigating a service and waiting list have not been found to be necessary.

How does the ability to pay (as a self-funder or recipient of state funds) impact on entry to co-operative care? In view of the funding

arrangement described in the body of this report ability to pay has little impact on the decision to enter a co-operative.

What is the co-op's role in terms of availability and accessibility of alternatives (to residential care) such as reablement services and domiciliary care and possible progression to residential or nursing home care? Some co-operative DHSEEs are investigating the possibility of offering their members a continuum of care: eg home care/housekeeping services – personal hygiene services – nursing/health care - long term residential care facilities.

How responsive is the co-operative care sector in Quebec to the level of demand? Very good.

How quickly can it respond to need/demands? Usually with a week or two.

What is the potential or actual achievement of the co-operative sector in terms of meeting the varied needs of significant numbers of older citizens? See figures for 2007 quoted in main report. Co-ops have proved to be more pro-active and entrepreneurial than other DHSEEs – eg by extending their range of services, providing support services to private residential homes and opening their own residential accommodation.

If services are available to both members and the wider community, what are the benefits of membership? Providing a sense of ownership and involvement by participation in board meetings etc. This enhances their status and staff respect. They would also share in any profits generated.

3. Glossary

Co-operatives

A Co-operative is an organisation with members who have a democratic say in how the enterprise is run and what should be done with any profits/ surpluses. They should conform to internationally agreed principles: ie membership must be open and voluntary, each member must have an equal say in the management of the organisation which must be autonomous and independent of the state, information, education and training must be provided for members, they must co-operate with other co-operatives and they must show an active concern for the community. Co-ops may be user co-operatives, worker co-operatives, producers' co-operatives or multi-stake co-operatives, which combine more than one of the above categories. Multi-stake co-operatives were legally recognised in Quebec in 1997. Most co-operatives in Quebec are now multi-stake co-ops and many, if not most, also have an additional category of Supportive Members. Such members share the aims of the co-op but do not share in its day-

to-day activities. They are seen as particularly valuable in service providing co-ops where they can provide a range of additional experience/expertise.

Social Economy Enterprise:

Following the major Socio-Economic Summits held in Quebec in 1997 it was agreed that a Social Economy Enterprise must:

- Serve their members and the local community instead of prioritising profits
- Be autonomous of the state and have independent management
- Have a democratic process involving users and workers in their operations
- Use any surplus to promote people and work
- Build their activity on the basis of participation, self-help and individual and collective responsibility.

Domestic Help Social Economy Enterprises (DHSEEs)

In practice, DHSEEs are either Not-for-Profit Associations (NPAs) or Co-operatives. Co-operatives are governed by Quebec Co-op Law (more than 300 articles!) and the name "Co-operative" is legally protected in contrast to the position in the UK. In particular, in relation to Multi-stakeholder co-operatives, no member can belong to more than one category of membership and supportive members are limited to a maximum of 33% of the seats on the Board. NPAs are much less restricted. They may decide for themselves who can be accepted as participants in the venture, the composition of their Board etc. The only restriction placed on them is that they must be non-profit making. As such, they cannot address the accountability gap which is associated with private for-profit services and all too often with public services as well. By their very nature, it is only multi-stakeholder co-operatives that can address this accountability gap.

Health and Social Care Committee

HSC(4)-05-12 paper 2b

Inquiry into residential care for older people - Supplementary evidence commissioned by Wales Progressive Co-operators from Jean-Pierre Girard - Additional information

Co-operative models of care for older people

The Quebec experience 1997-2012

Jean-Pierre Girard M.A. B.Sc. B.A.

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The wider Canadian experience

John Restakis

January 2012

A report commissioned by the Wales Progressive Co-operators, Cartrefi Cymru, Public Health Alliance Cymru, and the Wales Food Alliance

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Co-operative models of care for older people

FOREWORD: The context in Wales

Today's opportunities to implement Co-operative principles within home care services for older people.

Social care in the UK and Wales is in a state of flux. An ageing population and the economic context of cuts and debt reduction have put services under severe pressure. The main providers of services are local authorities, although local authorities commission significant parts of the third sector and private provision. All these organisations suffer from deficits in citizen engagement, involvement and influence. This remains true despite recent efforts to overcome the baggage of historical organisational models, which have high levels of bureaucracy and a top-down management approach.

The vast majority of older people in Wales manage their own lives with the assistance of families and friends and do not receive social care services from local authorities. Yet within this group there is a considerable level of unmet need. As local authorities tighten their eligibility criteria, the proportion of older people receiving local authority services will be less. This is likely to continue into the foreseeable future. These financial constraints not only limit the local authorities' own services but also its ability to commission services from the third sector and private businesses. This situation is forcing local authorities and the Welsh Government to examine innovative services and modes of provision, such as extra care housing, assistive technology and improving information services.

Across the economy, co-operative models of organisation have a long history in the UK and within Wales. They have the potential to provide an effective alternative to present patterns of service provision. The experience in Scandinavia, Italy, Japan, and Canada and in particular Quebec (and recent pilot projects within England) throws valuable light on establishing and operating co-operative care services. Some of the potential advantages of co-operative models are: service users, workers and community supporters owning and managing their provision; partnership working between service providers; local employment opportunities and community enrichment; and stronger preventive services which enable older people to maintain independence and live in their own homes for longer with an improved quality of life.

Co-operatives Engage Members: Citizen engagement and involvement has been a powerful mantra in many public services in the last decade as well as third sector organisations – rather less so in the private sector. Yet there remains a deep scepticism that many forms of consultation are tokenistic and even when appearing to be undertaken in good faith citizens ultimately feel that they have little influence in key decisions. The advantage of multi-stakeholder co-operative is that they are organisations run for and by members, with service users, workers and community supporters having rights and responsibilities for service provision. In Wales some of this range of provision is already provided with public finance, for example, by Care and Repair, Crossroads, Age Concern, WRVS and churches.

The issue of ‘control rights’ for service users, as opposed to being passive service recipients, is equally relevant to such organisations.

Local Employment Opportunities and Community Enrichment: Co-operative organisations can be very local and evolve within co-operative structures to secure economies of scale. Multi-stakeholder co-operatives can provide a range of provision (e.g. domestic services; gardening; shopping; assistance with meals; befriending; social activities), and can potentially provide a mix of employment opportunities. There are links to greater opportunities for social interaction with peers; vocational education; adult education in enhancing people’s skills in management, bookkeeping and communications (both individual and group and IT). They can also improve the status and terms of employment for a predominantly feminised workforce.

Stronger Preventive Services: Local authorities in Wales are only providing services to those people deemed to have a substantial or critical need. The effect is that it is often when situations reach a crisis that any assistance is provided. At the same time there are many patients admitted to hospital because of a medical/social crisis who would not have needed a hospital admission had support been provided at an earlier stage. Similarly many patients remain in hospital for long periods through lack of support services in the community. Low intensity social care services, provided locally at an early, non-crisis stage, can reduce levels of admission to hospital or residential/nursing homes and the demand for high intensity services in health and social care. The contribution that low intensity social care services can make would positively support public health as part of a 21st Century agenda.

The Challenge: The institutional framework in Canada and Quebec has similarities but also differences from the UK and Wales, especially the highly regarded legal status of co-operatives in Quebec. The challenge is to be clear about some of the deep-seated problems in social care and health and to clarify the practical solutions which co-operative models can bring. This needs detailed work in disentangling some of our present complex structures and funding mechanisms in supporting a co-operative social care model, which would work in Wales and which would help to resolve some of the seemingly intractable problems in social care and health services in Wales.

Multi-stakeholder co-operatives: The determinants of health have a large social component. Multi-stakeholder co-operatives have the potential to unify provision of low intensity social care support services, which support social care, wellbeing, health, education and employment objectives. Wales can provide a beacon to other parts of the UK in developing genuine multi-stakeholder co-operatives, run for and by their members and in so doing help to avert any drift towards less accountable social enterprise.

Dr Ron Walton and Hilda Smith
January 2012

Co-operative models of care for older people

PART ONE: THE QUEBEC EXPERIENCE

1.1. Background

With a population of some 8 million, Quebec is the second largest province in Canada. Some 80% of the population are French speaking whereas in other provinces the vast majority are English speaking. The language situation has had a significant impact on the development of co-operatives in Quebec. The co-operatives came to be seen as a way in which the French speaking population could take control of their economic life outside of the big enterprises, which were mostly under the control of English speakers.

Over the last hundred years of Quebec history, the co-op model has become a key component of the economy, alongside the private and state sectors. In addition to large-scale co-op organisations in financial services (eg. the Desjardins co-op bank) and in the agri-food business, smaller co-ops also developed in diverse areas of activity, including consumer organisations, housing, funeral services, forestry and para-medics. Thanks to the recognition of "multi-stakeholder co-**ops", or 'social solidarity co-operatives'** in 1997, Quebec has now had fifteen years of co-operative expansion into new sectors and activities, including child-care, health and social care, tourism, outdoor activities, fair trade, and the environment. Quebec now has over 500 'social solidarity' co-operatives, with more than 50% of new registrants preferring this model than the 'single individual member' category comprising, for example, workers or service users.

Quebec is now unique in North America in the range and depth of co-operative activity throughout its economy and society, and in the way that co-ops are nurtured and supported by networks of organisations and by the policies of the Quebec government.

1.2. How co-operation is helped in Quebec

1.2.1. Support from government

The development of co-ops in Quebec benefits not only from expert support, networking and grants from other co-op organisations, but also from a favourable legal framework and numerous supportive public policies. All the political parties (liberal, nationalist, etc) that have governed Quebec in recent times have fully recognised the role of co-ops in the economy and have shown their support through their policies, laws and regulations.

1.2.2. Regional development co-ops (RDCs)

In order to support co-operative development in a new area of activity, the Quebec government has, over the past twenty years, funded a network of regional development co-ops that serve seventeen regions covering the whole province. The RDCs employ sixty specialists who support co-op development with legal aspects, business advice, and networking. Each RDC is itself a co-op, and together they have a membership of 1200 co-ops, allied organisations and individuals. Each RDC receives funds from the Quebec government for their day-to-day operations, and a bonus for every new co-op that is established in which jobs are either created, or are co-operative conversions from an existing business. Each RDC has their own board representing their membership and providing a strong link with their region's socio-economic reality and development challenges.

1.2.3. Supportive financial structures

Quebec has established a strong reputation in North America in terms of its financial system, with financial instruments dedicated to collective enterprise such as co-ops, non-profit associations, and "social economy enterprises". The author (JPG) sits on an investment committee of a risk fund that manages 10 million dollars dedicated to loans for co-ops and non-profit associations. (Note that each loan is given without the requirement of any traditional guarantee...).

The promotion of social economy enterprises (SEEs)

Although social economic activity in Quebec has roots in the late nineteenth century, it received a significant boost as recently as 1996 when a socio-economic "Summit" led to the creation of a network of non-profit associations and co-ops with the prime purpose of developing the social economy. In order to receive support an organisation must meet the criteria of a "social economy enterprise" as follows. It must:

- Serve its members or some wider social purpose, rather than focusing on profit and financial output
- Have management autonomy, rather than being a controlled dependent of the state
- Be governed and operated through a democratic process involving users and workers
- Prioritise the use of surpluses and income for the benefit of citizens and workers, rather than the interests of capital
- Base their activity on rules of participation, self-help and individual and collective responsibility.

Organisations, which embrace these principles and can thus be defined as SEEs may be either non-profit associations or co-ops. Despite this inclusive definition, there is an on-going debate within Quebec between followers of the co-op and mutual models of organisation and the newer non-profit but not necessarily co-operative models.

1.3. Co-operation in the field of home care

Provincial governments are responsible for health and social services in Canada and, consequently, provision across the country varies greatly. In Quebec, pressure from social movements and political circles has led to a significant development of social economy initiatives in the health and welfare field, in particular in relation to home support services.

Prior to 1996, home care for the elderly in Quebec was provided by a mixture of a) voluntary organisations, which depended largely on volunteer support, b) for-profit organisations (focussing mainly on fee-paying service users whom they regard as profitable customers) and c) three emerging co-ops. There was also a considerable amount of moonlighting (undeclared work) and many unmet needs in the population.

1.3.1. The creation of Domestic Help - Social Economy Enterprises (DHSEEs)

Following the socio-economic ”Summit” in 1996, and with notable pressure from the women’s movement, the idea of a “social infrastructure” with government funding was developed. This was intended to address major unmet social needs whilst at the same time creating formally recognised employment for women. A social economy working group was formed which drew up proposals aimed at creating a network of social economy enterprises (SEEs) that would deliver domestic help services to individuals with physical and cognitive disabilities.

Four main objectives were identified:

(1) To provide quality domestic help services
(2) To create quality jobs (especially for women)
(3) To combat undeclared work (moonlighting)
(4) To avoid substitution of public sector jobs

In order to augment rather than duplicate the services offered by the public sector, the range of services to be nurtured was identified accordingly. The main tasks identified for the DHSEEs in 1996 were:

(1) Housework – both light and heavy
(2) Laundry & ironing
(3) Errands and purchase of groceries
(4) Preparation of non-diet meals
(5) Light outdoor maintenance work.

(Over time, these services have been extended to include:

(6) Personal hygiene services such as waking, bathing, dressing and assistance with eating
(7) Civic assistance such as help in venturing outside the home, form filling etc.

(8) Family relief such as sitting with people to allow free time for carers and longer periods of respite care.)

The 1996 working group recommendations were agreed and a network of DHSEEs was established in each of Quebec's 17 regions. The idea was to create a DHSEE for every 'territory' with a public health clinic of which there are 103. A selection process was established to provide official recognition of these DHSEEs. Some were established by recognising existing services providers, others by an agreed merger of existing charitable organisations whilst others were newly established organisations deemed to have the capability of fulfilling the tasks outlined.

At the end of the start-up process, 104 DHSEEs were recognised. Of these, 57 were Non-Profit Associations and 47 were Co-ops – see Appendix iii. for details of the difference between these two kinds of organisation. Most of the co-operatives opted for the multi-stakeholder / social solidarity structure, rather than the single member category – again see Appendix iii.

By 2007 there were 101 enterprises in operation (54 NPAs and 47 Co-ops), which between them provided 5.1 million hours of services to over 76,000 people. They had sales close to $106 million and employed 6,000 staff (nearly 90% of whom were women).

1.3.2. How the Domestic Help SEEs were helped to become established

A Federation of DHSEE co-ops was formed at the outset in 1996 offering a forum for exchanging views and providing training and advice for board members, advice on human resource issues, implementation of common management software, setting and monitoring quality standards, business development support, legal advice etc. A similar organisation was established for NPAs, but that has tended not to be as effective as the Co-op Federation and has since fragmented.

New enterprises also benefit from pump-priming funds including start-up grants and funds from the anti-poverty programme, which are used to subsidise employees' salaries.

The network of 11 Regional Development Co-operatives (RDCs) covering all 17 regions of the province were and are a major source of support for co-op development, including home care co-ops. (See section 2 above re RDCs.)

1.3.3. On-going funding for domestic help

The Quebec Government adopted a scheme known as "Financial Assistance for Domestic Help Services". This states that:

"Persons using domestic help services provided by a Domestic Help Social Economy business that has been accredited for program purposes may receive financial assistance applicable against the hourly rate the business charges. There are two types of financial assistance:

- Basic financial assistance of $4 for each hour of services rendered is granted to any eligible person regardless of family income

- Variable financial assistance of $0.55 to $8.25 for each hour of service rendered may be granted over and above the basic financial assistance, and is determined on the basis of the eligible person's family income and situation,

The person pays only the difference between the rate charged by the business and the financial assistance granted".

There is also a tax-credit for home support for seniors aged over 70 "so that they will not have to move to an establishment in the public health and social services network or so that they can delay having to make such a move".

Most of the income of individual DHSEEs comes from the charges made to service users, but this is backed up by a provincial government grant representing between 15% and 20% of their total revenue. Most of the expenditure of individual DHSEEs (80-95%) goes on salaries and other staffing costs.

1.3.4. Key challenges for the future

As has been stated above, the original list of tasks for which the DHSEEs were intended has (since 2004) been extended to include hygiene services, civic assistance and family relief. With the increasing demands of a growing older population, questions are now being asked as to whether the Quebec government should extend its financial assistance to DHSEEs so that they can offer their members an even larger continuum of services, in partnership with other elements of the co-operative social economy and local public health authorities.

For example, can home care co-ops collaborate with health co-ops to better meet the health needs of members? Can they collaborate with housing co-ops in order to offer accommodation with services (cafeteria, health support)? Can they collaborate with transport co-ops or paramedic co-ops for the provision of non-emergency transport? Can they collaborate with funeral co-ops to help members with their end-of-life planning?

The widespread and highly regarded infrastructure of co-operative home care, within a vibrant wider social economy, means that Quebec has options and opportunities for addressing its social needs which are unparalleled in north America and much of Europe. And these options are not only more cost effective than undiluted state care or contracted private care, they are also empowering of the citizen and strengthening of civic society.

Co-operative models of care for older people

PART TWO: THE CANADIAN EXPERIENCE

This section of the report is a Wales Progressive Co-operator resume of extensive research findings set out in "Co-op Elder Care in Canada", a report by John Restakis published in 2008

2.1. Introductory observations

"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….The kind of responsive, humane care that 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".

"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…… 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".

"Informal carers 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 institutionalised settings".

"The impression of elder care in Canada is a system wholly inadequate to address the growing needs of seniors…..The system has been described as patchy, unaffordable and unresponsive to the real needs of people …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….that run services for profit, usually under contract to government bodies".

"The number of seniors who have been cut off or are unable to access basic care has increased dramatically".

2.2. Most urgent gaps

- Affordable housing
- In-home support services which …often make the difference between relative autonomy and dependence
- More beds for both acute and alternate care are needed; people who do not need acute care beds should be placed more appropriately
- Transportation difficulties & closure of small local hospitals has entailed additional costs for relatives
- Increased cost of pharmaceuticals is a problem for many

2.3. What policy changes are needed?

"Any new policies should be developed in consultation with local communities and seniors' organisations to ensure that policies respond to the unique needs of individual communities"

"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 the co-operative model."

2.4. Social Care Services provided by co-ops.

a) Housing is the most common: options include apartments, townhouses, freestanding dwellings, shared living arrangements and handicapped units. Some are market housing, others subsidised. Some are exclusively for seniors, others for mixed families or other age groups as well.

b) Assisted living & Home care services are the second most common: typical services include cleaning, lawn care, snow shovelling, shopping, cooking, transportation, counselling, hairdressing and visiting. Some of these services are provided by housing co-ops, but some co-ops focus exclusively on the provision of home care services (especially true of Quebec).

c) Social & Recreational services: eg social outings, exercise & yoga classes, bible reading classes, gardening, games clubs and the organisation of social events. Such services are predominantly provided within housing co-ops.

d) Health care: Health care co-ops provide services to the general public but have been cited as particularly relevant to seniors on account of their flexible and innovative response ..to this age group.

e) Funeral services: as above such services are available to the general public.

2.5. Membership of co-ops

The size of membership varies from 1,000 in a housing co-op (of which only 20% are seniors) to a co-op of 3 members providing home care services.

Many co-ops are worker co-operatives whose members are care givers, but others include members with a variety of interests such as users, employees, community members and organisational sponsors or supporters and volunteers.

2.6. Sources of Funding

In housing co-ops the largest source of funding comes from member shares or life leases (see below) and rentals. They also receive some subsidy from government sources and some attract funding from private business. Start up funding has come from private donations, churches, foundations and loans from local credit unions.

The Housing & Urban Development Agency in the USA has special funding earmarked for seniors' co-ops as well as allowing co-op members to receive the same tax benefits as homeowners.

2.7. Advantages of the Co-op Model

a) Control rights: "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….(It) 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"

b) Previous research shows that 61% of respondents (ie co-op residents) said that they were either somewhat or extremely active in the governance of their co- op while only 9% were not at all active. 85% 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".

c) 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.

d) Service quality: "This has been a key factor in attracting a growing number of seniors to the co-op model … There is no incentive in a co-op structure to short change service quality for considerations like profit maximisation. ….The same has been found in studies of co-operatives whose members are caregivers (where) co-op members have the power to design and deliver services without the need to flow profits to private investors; this means that service content will better reflect what is in the best interest of caregivers".

e) Studies in Italy and another by Kansas University have confirmed that the above advantages of a co-op model are replicated elsewhere and that "the co-op model still delivers the most affordable form of housing when compared to social housing".

f) Reduced health care costs: "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". "The consistency of …results across time, provinces and countries suggests that residents living in for-profit facilities are more likely to be hospitalised than residents living in non-profit facilities".

2.8. Challenges of the Co-op Model

a) Lack of awareness: This is true both among the general public and among funders and policy makers. This often leaves co-ops "scrambling to access sources of financing".

b) Reluctance to share power: some government agencies display apprehension on this score.

c) Complexity of the Co-op development process:

d) Capital Accumulation and Enterprise Investment: largely a problem of building up enough reserves for development plans.

e) Lack of managerial expertise: This is an "inherent weakness that can only be overcome if members recognise that the expertise required to sustain the co-op may have to be sought outside the available skill set of the co-op"…. "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".

2.9. Canadian Task Force Recommendations

The more important recommendations for a Canadian Task Force included:

- Improvement of income support systems for seniors
- A national coalition/campaign for the advancement of senior policy leading to a national elder care strategy backed by a degree of government funding
- Creation of housing programmes that address senior's needs (eg a requirement that a percentage of all new housing be set aside for seniors)
- Improvement of compassionate care leave programmes
- Explore the use of tax credits to support elder care services
- A guide/toolkit for use in community dialogues on elder care
- A national support system to develop and support elder care co-ops (financing, technical support, possible foundation and pension plan support etc.) and to mobilise co-op sector resources to support social care co-ops.

2.10. Examples of the different kinds of social care co-ops

Life-lease Co-ops

This model can apply to housing co-ops where the members purchase life leases, the proceeds of which go towards the development cost of the housing. The co-op retains ownership of the housing unit and the value of the lease is returned to the users when they no longer occupy a unit.

Sometimes life leases are sponsored by local organisations that act as guarantors for the initial development; such organisations might be seniors' groups, social service agencies, credit unions, labour organisations and faith groups. Many seniors are able to finance the purchase of a life lease from the sale of their existing homes.

An example of this kind of co-op is the *McClure Place Foundation* in Saskatoon. It was initially sponsored by the McClure United Church. There were 130 member residents (in 2008), 36 of them subsidised by the provincial government. Fund-raising is also undertaken to subsidise low-income residents.

Purchase price of a lease was $105,000, which is loaned to the co-op as a non-interest bearing loan, which does not affect any government income support entitlement. Residents also pay $450 per month to cover operating costs and the building of a reserve. A part time nurse is available, 24 hour security, fitness equipment, social programmes, an activity director and personal laundry services.
There is a long waiting list and the model is being copied across Canada.

Equity Co-ops

Equity co-ops are similar to the life-lease co-ops except that members own the unit they occupy. In some equity co-ops members are required to take a second mortgage on their unit, which is repaid at the time of resale. The proceeds of this 2nd mortgage are used to finance new co-op housing projects.

An example of this kind of co-op is *Ambleview Place Housing Co-op,* in West Vancouver. This is a 4 storey building with 42 units – each with its own underground parking lot - and a number of shared amenities (lounge, meeting room, workshop, laundry). The units are of varying sizes.

The project was initiated by the local council who advertised a plot of land for non-profit senior housing. A co-op development proposal from a local architect was accepted and the land leased at 67% its market value for 60 years on condition that the building was maintained for non-profit making seniors' housing. A credit union provided construction costs and individuals had to pay a deposit of 25% of the value of their unit prior to construction.

The credit union also arranged mortgages for those who needed them for the extra 75% individual members had to pay before occupation.

When completed, unit prices ranged from 73% to 83% of the local market value and this degree of affordability has to be maintained for future members. Members also pay monthly fees of $100 to $164 towards a sinking fund and common charges. Property taxes are paid separately, but amount to some $400 pa.

"This approach, which combines a favourable land lease with equity contributions from co-op members, can be readily replicated in other municipalities".

Foster Care Co-ops

This is a new care model recently developed which can provide an alternative for people not able to purchase or lease a housing unit. This scheme provides living accommodation to seniors in private homes. The members of the co-op are the home owners, most of whom also provide some degree of personal support – eg cleaning, recreation and socialising programmes and transportation. The co-op provides oversight, training services and quality control for all participating members.
Schemes are funded from payments made by the service users, sometimes supplemented by public subsidies available to seniors.

An example of this kind of co-op is the *Caring Connections Co-op* in Napanee, Ontario. This was still in its early stage of development in 2008, the aim being to provide a network of approved private homes able to offer an appropriate environment in which frail elderly people could maintain independent living. The co-op provides an umbrella organisation "to inspire excellence and promote respect, recognition, equality and service accountability in a team orientated atmosphere".
When fully operational, the co-op will have 64 seniors living in 40 foster homes with a limit of 2 senior boarders per home.

The co-op provides access to private rooms or suites and the right to choose preferred location and lifestyle preferences. Frail seniors pay $33 to $63 per day for incomes up to $24,000 plus. A government subsidy programme covers the balance of costs for lower income seniors. The home providers are paid by the co-operative for any support services provided. The co-op also organises:

- Monthly visits from a registered nurse
- Assistance with bathing where needed
- Quarterly visit by a wellness monitor to assess psychological well-being

The system provides accommodation and services tailored to individual needs. It improves well-being and reduces the need to call on emergency services and for hospitalisation.

Home Care Co-ops

Home care co-ops have taken off in Quebec – where the provincial government subsidises home care services - and are beginning to spread to other parts of Canada. The members may be care-givers, home care consumers – or both in a multi-stakeholder structure.

An example of this kind of co-op is *Care Connection* in Mission, British Columbia. The BC Co-operative Association and the BC Health Employees Union helped establish this co-op by providing technical assistance and organisational funding through a federal Co-operative Development programme. After four years (2008), the co-op has three members providing 365 service hours care to 97 clients, of whom 29 pay for the co-op's services privately, 66 are funded through the Veterans Independence Programme and two are funded by an insurance company.

Many referrals come from the home care agency that has the home care contract with the local health authority. The co-op itself has tried to secure a contract with the health authority but the small size of the co-op and their recent entry into the market has been a stumbling block in spite of the members' twenty five plus years experience of working in the sector and being registered care providers.

"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".

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APPENDICES

Appendix 1:

The wider context: UN Year of Cooperatives 2012

The informal alliance of agencies and progressive co-operators that has commissioned this report is seeking to inform the developing of social care in Wales by promoting awareness and understanding of co-operation as an ethical and practical approach to human interaction and organisation. It is an approach based on a commitment to principles of reciprocity and democratic accountability, and one that has enormous global support and contemporary relevance.

In March 2010 we organised, through WCVA, a study day, funded by the Cymru / Wales Co-operatives Membership, to provide foundations for the (re)development in Wales of a more thorough and contemporary understanding of co-operation.

To follow this, as our contribution to the celebration of the United Nations Year of Co-operatives 2012, we have not only commissioned this report but also arranged a visit to Wales of the Quebec author, Jean-Pierre Girard, who will be speaking at a seminar hosted by Rosemary Butler, AM, at Ty Hywel in Cardiff Bay, on February 7th 2012. M Girard has been intimately involved with home care co-operatives in Quebec since 1997. He has been a Commissioner and since 2001 a member of the board of the International Health Co-operative Organization (north America region); and a frequent contributor to OECD publications related to social enterprises. He has considerable knowledge of the incentives and decentralised resources for local co-operative development in Quebec. We hope his visit will help to give impetus to care co-operatives in Wales.

We are subsequently planning to support, and maximise the benefits from, the visit to Wales in July 2012 of another highly informed Canadian co-operator and contributor to this report, John Restakis.

These and other activities are our contribution to the celebration of the UN Year of Co-operatives 2012.

Our hope is that some of the lessons from Quebec and Canada (and beyond) can translate into positive action in Wales. In a context of a rapidly aging population and significantly growing elder needs, we hope to provide a spark to assist in the development of new forms of care in addition to state provision, following modern lines of involvement and participation but building on methods of reciprocity and co-operation that have developed over the past 160 years.

We also see through co-operation a great potential to improve the status and terms and conditions of employment of a predominantly feminised home care

workforce. By their very nature, “multi-stakeholder co-operatives”, as described in this report, offer a real opportunity to address this accountability gap.

We hope that Wales can provide a beacon to other parts of the UK in developing genuine stakeholder co-operatives and in so doing help to avert any drift towards less accountable mutuals, which could mask the privatisation of public services.

David Smith, Wales Progressive Co-operators

Adrian Roper, Cartrefi Cymru

Appendix 2

Some questions we put to Jean-Pierre Girard

1. How do people gain entry to co-operative models of Residential Care in Quebec?

The service is available to all.

2. Do people become members before they need care?

About 5%-10% do – mostly family members of households where a service is already provided. But this is not necessary. On receiving a service most recipients become co-op members as it increases their involvement in decision-making regarding the care provided.

3. Is there a members "waiting list" or are they referred to a co-operative by professionals of the state following an assessment of need?

   Recipients of care may be referred by a professional from a public service but many self-refer. There is usually little delay in instigating a service and waiting list have not been found to be necessary.

4. How does the ability to pay (as a self-funder or recipient of state funds) impact on entry to co-operative care?

   In view of the funding arrangement described in the body of this report ability to pay has little impact on the decision to enter a co-operative.

5. What is the co-op's role in terms of availability and accessibility of alternatives (to residential care) such as reablement services and domiciliary care and possible progression to residential or nursing home care?

   Some co-operative DHSEEs are investigating the possibility of offering their members a continuum of care: eg home care/housekeeping services – personal hygiene services –nursing/health care - long term residential care facilities.

6. How responsive is the co-operative care sector in Quebec to the level of demand?

   The sector is able to respond very well to the level of demand.

7. How quickly can it respond to need/demands?

   Co-ops can usually respond to needs and demands within a week or two of a request for assistance.

8. What is the potential or actual achievement of the co-operative sector in terms of meeting the varied needs of significant numbers of older citizens?

   See figures for 2007 quoted in main report. Co-ops have proved to be more pro-active and entrepreneurial than other DHSEEs – eg by extending their range of services, providing support services to private residential homes and opening their own residential accommodation.

9. If services are available to both members and the wider community, what are the benefits of membership?

   Providing a sense of ownership and involvement by participation in board meetings etc. This enhances their status and staff respect. They would also share in any profits generated.

Appendix 3:

Explanation of terms used in Quebec: Co-ops, SEEs, DHSEEs and NPAs

Co-operatives

A Co-operative is an organisation with members who have a democratic say in how the enterprise is run and what should be done with any profits/ surpluses. They should conform to internationally agreed principles: ie membership must be open and voluntary, each member must have an equal say in the management of the organisation which must be autonomous and independent of the state, information, education and training must be provided for members, they must co-operate with other co-operatives and they must show an active concern for the community. Co-ops may be user co-operatives, worker co-operatives, producers' co-operatives or multi-stake co-operatives, which combine more than one of the above categories. Multi-stake co-operatives were legally recognised in Quebec in 1997. Most co-operatives in Quebec are now multi-stake co-ops and many, if not most, also have an additional category of Supportive Members. Such members share the aims of the co-op but do not share in its day-to-day activities. They are seen as particularly valuable in service providing co-ops where they can provide a range of additional experience/expertise.

Social Economy Enterprise:

Following the major Socio-Economic Summits held in Quebec in 1997 it was agreed that a Social Economy Enterprise must:

- Serve their members and the local community instead of prioritising profits
- Be autonomous of the state and have independent management
- Have a democratic process involving users and workers in their operations
- Use any surplus to promote people and work
- Build their activity on the basis of participation, self-help and individual and collective responsibility.

DHSEEs and NPAs

In practice, Domestic Help Social Economy Enterprises (DHSEEs) are either Not-for-Profit Associations (NPAs) or Co-operatives. Co-operatives are governed by Quebec Co-op Law (more than 300 articles!) and the name "Co-operative" is legally protected in contrast to the current position in the UK. In particular, in relation to Multi-stakeholder Co-operatives, no member can belong to more than one category of membership and supportive members

are limited to a maximum of 33% of the seats on the Board. NPAs are much less restricted. They may decide for themselves who can be accepted as participants in the venture, the composition of their Board etc. The only restriction placed on them is that they must be non-profit making. As such, they cannot address the accountability gap which is associated with private for-profit services and all too often with public services as well. By their very nature, it is only multi-stakeholder co-operatives that can address this accountability gap.

Appendix 4 Biographical details: Jean-Pierre Girard

Jean-Pierre Girard MA, BA, BSc
http://www.productionslps.com/en/default.html

Jean-Pierre Girard is a specialist of **development and management of collective enterprises** such as co-operative, non-profit organization (NPO) and mutual. He has been involved in this area for 25 years, combining practical and academic experience, with roles as executive director, member of a board, consultant, speaker, writer, and teacher.

He has worked for, including as first executive director of, the Quebec Housing Co-op Apex Organisation (Confédération québécoise des cooperatives d'habitation) supporting1200 housing co-ops providing 25000 apartments.

He has taught courses related to collective enterprises in different universities including the Université de Montréal, Université du Québec à Montréal, Université de Sherbrooke, and Université Senghor (Alexandria, Egypt)

Since 1983, he has been involved on the board of up to 20 corporations in the Non-Profit, Co-op, and Public sectors (including, a regional public health board and three regional development co-operatives).

Since 2001, he has been a member of the investment committee of a risk fund with $10 million assets dedicated to collective enterprise in Quebec (le Réseau d'Investissement social du Québec):
http://risq.zonehttps.com/?module=document&action=get&uid=990

Since 1996, he has developed a specific **expertise in health and social care co-ops** from local and international perspectives. He has conducted many surveys, published numerous papers and research reports.

In 2006, he released the book: *Notre système de santé, autrement L'Engagement citoyen par les coopératives* (Our different health system: Citizen involvement in co-operatives) a book showing the contribution of the co-operative model to improving the health care system in Quebec and more globally, in Canada, including inspiring examples from Japan and Belgium.

In 2007, he was on the editing committee for a special issue of the review *Making Waves* under the name *Community-controlled health care*
http://www.cedworks.com/mw1803e_01.html

In 2008, the Organisation for Economic Co-operation and Development (**OECD)** asked him to write a chapter related to the specific example of multi-stakeholder co-ops in Quebec including health and social care cases. The book was released in 2009, *The Changing Boundaries of Social Enterprises*
http://www.oecdbookshop.org/oecd/display.asp?CID=&LANG=EN&SF1=DI&ST1=5KZ9HDCMB3LS

In 2007 and 2010, he organised a Canadian Study Tour to Japan in order to have a better comprehension of the way health co-ops in that country tackle ageing population issues such as health, accommodation and related services.

Since 2001, under a Canadian Co-operative movement mandate, he has served on the board of the International Health Co-operative Organisation (IHCO), a sectoral organisation of the International Co-operative Alliance. The board sits in different places around the world, Europe, Asia-Pacific, South and North America.

From 2003 to 2008, he has been a member of the Health Committee of the Conseil québécois de la coopération et de la mutualité, the Quebec co-operative and mutual apex organization.

As a consultant, he is involved in key new health co-op projects and also working for the Government of Canada (Rural Affair and Co-op Secretariat) and Quebec Co-op and Mutual Apex organization (Conseil québécois de la coopération et de la mutualité). He has also worked as a consultant with an important NGO in order to offer training course for the development of health mutuals in Africa and South America.

In 2011, he was selected as a member of a Canadian panel for the 3 M Health Leadership Award, a price that recognizes outstanding community leaders that have had an impact on the health of their community by addressing at least one of the social determinants of health (www.healthnexus.ca)

Health and Social Care Committee

Cynulliad Cenedlaethol Cymru

National Assembly for Wales

Meeting Venue:	**Committee Room 3 – Senedd**
Meeting date:	**Wednesday, 25 January 2012**
Meeting time:	**09:30 – 11:00**

This meeting can be viewed on Senedd TV at:
http://www.senedd.tv/archiveplayer.jsf?v=en_400000_25_01_2012&t=0&l=en

Concise Minutes:

Assembly Members:

Mark Drakeford (Chair)
Mick Antoniw
Rebecca Evans
Vaughan Gething
William Graham
Elin Jones
Darren Millar
Lynne Neagle
Lindsay Whittle
Kirsty Williams

Witnesses:

Lesley Griffiths, Minister for Health and Social Services
Dr Chris Jones, Welsh Government
David Sissling, Welsh Government

Committee Staff:

Llinos Dafydd (Clerk)
Catherine Hunt (Deputy Clerk)
Victoria Paris (Researcher)

1. Introductions, apologies and substitutions

1.1 There were no apologies or substitutions.

2. Scrutiny of the Minister for Health and Social Services

2.1 The Minister for Health and Social Services and officials responded to questions from members of the Committee.

2.2 The Minister agreed to provide additional information as requested by the Committee on: the number of vacant doctor posts in Wales and their grade; the criteria that will be used to measure the success of the upcoming campaign to recruit doctors

to Wales; and the number of health visitors required to double the number of those benefiting from the Flying Start Programme.

2.3 The Minister agreed to update the Committee on discussions with the UK Government on the regulation of private cosmetic surgery providers and to provide updates on wheelchair services and support for armed forces veterans in Wales.

3. Committee forward work programme - EU matters

4.1 The Committee agreed that its main pursuit of EU matters for the spring and summer term should be through comparative work for the inquiry on residential care for older people.

4.2The Committee requested further information on EU models of residential care, including not for profit models used in other countries and any information gained by the Welsh Local Government Association through the twinning of local authorities in Wales with European counterparts.

4.3 The Committee requested further information on the health strategy, the Professional Qualifications Directive and cross-border access to healthcare.

4. Papers to note

4.1 The Committee noted the minutes of the meeting held on 11 January.

TRANSCRIPT

View the meeting transcript.