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Supporting older people to age well at home: Assessing the potential of care co-operatives in Ireland

Dr Carol Power and Dr Caroline Crowley









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Supporting older people to age well at home: Assessing the potential of care co-operatives in Ireland

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List of Acronyms

CDHS	Consumer Directed Home Support
CDU	Cooperative Development Unit
CECOP	European Confederation of Industrial and Service Cooperatives
CGSCOP	French General Confederation of Producers' Cooperatives
CHCA	Cooperative Home Care Associates
CLG	Company Limited by Guarantee
CSO	Central Statistics Office
CTT	Cultural Transformation Theory
ESF	European Social Fund
FRC	Family Resource Centre
FRCNF	Family Resource Centre National Forum
GAA	Gaelic Athletic Association
GCC	Great Care Co-op
GDP	Gross Domestic Product
GP	General Practitioner
HCSA	Home Care Support Assistant
HSE	Health Service Executive
ICOS	Irish Cooperative Organisation Society
IHREC	Irish Human Rights and Equality Commission
LDC	Local Development Company
MARA	Maximising Access in Rural Areas
MRCI	Migrants Rights Centre Ireland
NPM	New Public Management
OECD	Organisation for Economic Cooperation and Development
PHN	Public Health Nurse
SEM	Social-ecological Model
SHC	Sláintecare Healthy Communities
UN	United Nations

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Executive Summary

Introduction

In Ireland most older people prefer to remain in their own homes or, at least, in their own communities rather than in institutional settings, as they age (O'Sullivan, et al., 2022). Many people in older age need care and support in the home to enable them to fulfil this desire. While families tend to be the primary caregivers, professional home support is also essential for many older people. For the majority, this is accessed through the free public home support scheme, based on assessment of care needs; a smaller number of older people purchase care services directly from private providers.

The Health Service Executive (HSE) is responsible for assessing individuals' care needs and for providing approved care, either directly by HSE-employed staff or by external providers contracted to deliver care services on its behalf. In recent years, the commissioning of home care services by the HSE through a competitive tendering process has driven the commodification and marketisation of care (Cullen, 2019), which has led to substantial growth in the for-profit care sector and, particularly, multinational care company chains (Mercille and O'Neill, 2021, 2022). This policy evolved in the context of a transition in recent decades by the Irish Government to a neoliberal model of home care driven by cost efficiencies and the application of business management principles to public services. Through the care system, as it is currently structured, the State undervalues what it regards as the 'natural' work of care that takes place in the economically invisible space of the home. In addition, the State facilitates investor-owned firms to extract profit from delivering professional care services, which themselves undervalue the labour of care workers.

Failure to value care work appropriately leads to an underfunded voluntary sector and the subcontracting of care through a commissioning process that favours large, often multinational for-profit providers. The extractivism of companies that are owned by profit-seeking investors is more likely to result in poor pay and conditions, precarious contracts, low levels of job satisfaction, stress and burnout, and lack of career development opportunities, all of which negatively impact recruitment and retention of care workers. This labour supply challenge is compounded by an ageing care workforce, characterised by significant numbers of recent and impending retirements. As a result, despite having an increased budget for home care services in recent years, the HSE has struggled to provide approved care hours to clients due to staff shortages.

These issues do not only affect access to home care. Pressurised schedules and rigid, hierarchical structures of care services can compromise the quality of care too. Older people who rely on the public system may be rendered passive beneficiaries, where they are disempowered and have little input into how their home care is delivered.

Ireland's population is ageing. Central Statistics Office (2018) projections indicate that between now and 2051, the population in the 70+ age group is likely to more than double to reach 1.2 million. The confluence of an ageing population, a preference to age in place (especially in one's own home), and a shortage of people willing to work in home care, presents a significant challenge for Irish society. This calls for innovative solutions that foreground care in a reformed care system: one that values and appropriately rewards care work, respects older people's rights, and supports them to experience the best quality of life possible.

In this context, this report focuses particularly on exploring the potential offered by the co-operative model to empower older persons, family carers and professional care workers to co-create high-quality home care within a relational framework.

A co-operative is an enterprise owned and controlled by its members, i.e. those who use its services and/or work in the organisation. Key factors differentiating co-operatives from private home care providers are their purpose and ethos. Care co-operatives are designed to meet the mutual needs of members and focus on service rather than profit. Inclusive, democratic structures and processes, and the co-operative values of self-help, self-responsibility, solidarity, democracy, equality and equity, underpin the empowerment of care recipients, family carers and care workers, to create a better mutual experience of care.

This report represents the culmination of the CO-AGE project, which sought to explore the co-operative model of home care provision and consider its potential to be developed in Ireland. The project was funded by the Irish Research Council's New Foundations scheme, which supports research undertaken by academic researchers in partnership with civil society organisations. Age Action was the civil society partner in this project.

Research Objectives

The objective of this study was to explore with stakeholders whether and how the home care co-operative model could be developed in Ireland to enable older people to age well at home. It sought to examine the particular characteristics of the co-operative model in terms of offering better working conditions for care workers and better experience of care for older people and family carers. It also sought to consider what practical and policy supports would be needed to facilitate the establishment of such co-operatives, what challenges they might face, and how existing knowledge and expertise within communities and the co-operative sector could be leveraged to support the development of these co-operatives.

Methods

This was a qualitative study that was designed to engage stakeholders in discussion on the potential of the co-operative model to provide a solution to future home care needs in Ireland.

- In Ireland, the application of the co-operative model beyond credit unions and agriculture is not widely understood. Therefore, to raise awareness of, and garner interest in learning more about, the care co-operative model, the research commenced with a public webinar to introduce the model in the context of the home care sector. Speakers included representatives from two innovative care co-operatives in Ireland and the UK.
- Subsequently, focus groups with 17 participants with lived experience as older people receiving care, as people planning for future care needs, as family carers and as people working in the care system, explored whether and how the co-operative model could enhance home care in Ireland.
- Finally, focus groups involving 10 professional stakeholders with expertise relevant to the potential development of care co-operatives in Ireland assessed key considerations regarding the development of viable care co-operatives and the ecosystem required to support them.

- As part of a validation process, all focus group participants were subsequently invited to a final webinar where initial findings were reported, and participants were given an opportunity to provide feedback on the analysis and emerging interpretation of the results.

Ethical approval for this study was granted by University College Cork's Social Research Ethics Committee.

Limitations

As this was a small-scale exploratory study, the researchers were able to engage with a small number of participants. Given the small sample size, and the possible influence of self-selection bias, their openness to the co-operative model cannot be assumed to be representative. Further research would be required to investigate the extent of interest among the wider population in setting up care co-operatives. Reports from care workers who had experienced the co-operative model were also limited to a small sample.

Research Findings

The Experience of Care

By employing the multi-level Social-Ecological Framework, that reflects the interacting tiers in which care is experienced, shaped, supported or restricted, a picture emerged of research participants' current experiences of home care and the wider care system in Ireland.

Individual level: Older people seek to maintain their autonomy or freedom of choice, as well as their connectedness – to family, home and community – in their older years. Thus, most participants indicated a preference to remain in their own homes or, at least, in their own communities rather than in institutional settings, as they aged where they could maintain connections with their local networks and to younger generations. To achieve this desire to age in place, a range of local supports along a continuum-of-care, including home care, would be required to ensure that appropriate support is accessible and adaptable to individuals' diverse and changing circumstances.

Close relationships level: Care is a relational process in which family members often play a vital role, including in the planning for and managing of one's care in older age. The research documented relatives helping older people with house adaptations, adapting their own homes to accommodate a parent and/or becoming a family carer. Being a family carer had implications for their own livelihoods as some combined caregiving with work while others left jobs to become a carer, including several who returned from overseas to do so. Possible consequences of being a family carer included negative impacts on their well-being and income.

Community level: The place where one lives is an important site for fostering, deepening and harnessing relationships of mutual support among local households and families, together with local groups and organisations, including care services. Relationships of mutual support build community spirit or social capital, which can provide the fertile ground in which organisations (including care co-operatives) may take root. However, ongoing rationalisation and centralisation of private and public services, particularly in rural areas, is leading to fewer opportunities for local people to meet with one another and is undermining the relationship-building essential to maintain the social fabric. To counter the social isolation experienced by givers and receivers of care within the private domain of the home, research participants shared a desire for local, open-door venues where care might be brought out into the public domain and made visible at community

level. They also began to link the concept of 'care' with the idea of a 'co-operative' at this level, especially for communities where the social fabric was strong and there were higher levels of social capital.

Society level: At this level of the social-ecological framework, the value system underpinning care in Ireland was called into question by the evident failure of the State in its duty of care to older people, to their family carers and to care workers. Older people expressed concern and fear for their own future care prospects. Family carers outlined their struggles to sustain their care of loved ones due to inadequate supports, and to maintain their own mental and financial well-being. And care workers described being driven from an uncaring sector.

Specifically:

- The current home care system is made up of a profit-driven private sector, a cost efficiency-driven public sector and an under-resourced community and voluntary sector.
- The resulting 'conveyor-belt care' disrespects and disempowers givers and receivers of care. Staff burnout and poor terms and conditions of care work are leading to staff shortages and to older people together with their families struggling with inadequate care services.
- State bureaucracy is experienced by older people and family carers as a barrier to overcome rather than an enabler of access to essential supports. Tendering processes constitute a barrier to smaller care providers who cannot compete with large care chains that benefit from economies of scale.
- The current narrow medical model of home care prioritises personal care without regard for older people's need for a more comprehensive range of social care in order to age in place. The lack of a care continuum across the lifecycle means that the system cannot offer the necessary range of supports, housing options and living arrangements, and this culminates in the premature institutionalisation of older people within hospitals or nursing homes. As well as being the most expensive options, this goes against the wishes of most older people (and their loved ones) who would prefer to age in place, among their families and within their communities.

Altogether, the testimonies reveal an uncaring system that is failing the people at its heart – the givers and receivers of care.

Advantages Offered by Co-operatives for Creating Desired Care System

The need for a root-and-branch transformation of home care provision offers an opportunity. It is driving the impetus for social innovators – individuals, organisations and communities – to respond to the failures and gaps in the current system. Through grassroots action, they are developing building blocks for a reformed and desirable system, one that appropriately values and rewards care. During the research, examples of this were heard from two care co-operatives: the Great Care Co-op in Ireland and Equal Care Co-op in the UK. They are seeking to transform how care is experienced by those who give and receive care, based on values of solidarity, empowerment, and respect, along with a stronger focus on the care relationship.

In light of the problems and deficiencies related by focus group participants who had experienced the care system as people receiving care, family carers and paid care workers, there was keen interest in exploring alternative models and, in the context of this study, the care co-operative model in particular.

Based on testimonies from care co-operative founders and workers who had experienced being part of a worker co-operative, the following findings emerged.

Co-operatives can provide a better experience for care workers:

- Better pay and conditions, including pensions, reimbursement of expenses, greater flexibility in work schedules.
- Innovative and inclusive management and work practices, which recognise the insights and expertise of care workers and enable them to co-design and deliver care that is customised to the client.
- Inclusive, democratic governance, where care workers have opportunities to learn about the business and represent their co-workers on the board of directors and/or committees.
- Less hierarchical structures that permit more dynamic relationships between care workers and professional stakeholders, such as general practitioners (GPs) and public health nurses (PHNs).

Co-operatives can provide a better experience for care receivers:

- The evolving relationship-centred care model recognises the right of those receiving care to have a say in how their care is delivered. It challenges the conveyor-belt care system's rendering of care receivers as passive recipients. Relationship-centred care recognises the importance of the relationships between those providing and receiving care and facilitates the delivery of customised care that is agreed by mutual consent between care workers, care receivers and their supporters.
- In contrast to many large chains of for-profit companies, where services are designed at a distance from those receiving care, co-operatives have a greater affinity with communities and a better understanding of local circumstances. Spatial and relational proximity are important for the quality of care and for the provision of wrap-around services that ensure older people are truly integrated into the local community.

Limits to difference imposed by incorporation into the existing care system

When working with private paying clients, co-operatives have the flexibility to deliver care in a way that that is mutually agreeable to care receivers, their advocates and care workers. When undertaking work on behalf of a commissioning authority, such as the HSE, their flexibility and autonomy to deliver this type of customised service may be compromised by the need to conform to the system.

From Concept to Reality: Ownership, Registration and Viability

Based on the ethos and values underpinning the care co-operative model, and the positive testimonies from those with experience of the model, the idea of a care co-operative was attractive to many focus group participants. Translating the concept to reality in a local community raises a range of considerations in relation to the ownership, set-up, governance and viability of the co-operative. The researchers explored these issues with participants in the professional stakeholder focus groups. These participants had a range of expertise in relation to co-operatives, community finance, local and community development, home care service provision, and advocacy for carers and older people.

Ownership

Care co-operatives typically take the form of either a worker co-operative, owned and controlled by care workers, or a multi-stakeholder co-operative, which can include workers, care recipients and their advocates, and public and community organisations with a role in care provision. Among the focus group participants, there was strong support for workers having an ownership stake in the co-operative. Empowering workers by giving them a stake in the ownership and governance of the co-operative is an important step in enabling organisational and operational models that value care work and care workers.

Registration

In Ireland, not all organisations that operate according to co-operative principles actually register as co-operatives, instead choosing to register as a company limited by guarantee (CLG) or as a charity. This has been attributed to lack of awareness and poor understanding of the co-operative model among those providing enterprise support and legal advice, and the perception that current legislation governing co-operatives is cumbersome in terms of establishment and ongoing compliance. However, registering as a co-operative from the outset offers significant advantages, such as structures and rules that facilitate democratic governance, and the provision of mechanisms to deal with any conflicts among stakeholders. This enables the group to uphold co-operative values and principles.

Viability of the co-operative

A viable care co-operative is developed in the context of needs experienced by a critical mass of people who then coalesce around the idea of a bottom-up response. These needs include access to high-quality care within communities and decent pay and working conditions for care workers. The viability – both financial and non-financial – of a proposed co-operative must be considered carefully.

In terms of non-financial viability, the co-operative as a democratic enterprise relies on the support of a committed group of stakeholders who will actively support the endeavour, including individuals who are prepared to serve on the board of directors, and represent the members' interests. Furthermore, it is important that the co-operative has access to a pool of volunteers who, collectively, have a balanced skills mix and are willing to engage in training that will enable competent and effective governance.

In terms of financial viability, while co-operatives are not motivated by profit, they still need to be economically viable. It is essential that there is a business plan that will enable the co-operative to generate sufficient revenue to cover costs and, over time, generate surpluses, which can be used to build up financial reserves and reinvest in the development of the enterprise or other initiatives agreed by the membership. This requires the articulation of a clear value proposition. For those receiving care and their families, excellent care would include the co-design and co-production of care, which is more attractive than the conveyor-belt care typically experienced by clients in the current care system. To ensure that the co-operative can compete with other providers to attract care workers, there is also a need to articulate and communicate the value proposition from a worker perspective. Better working conditions, respect for care work, and opportunities to have a stake and a say in how the co-operative is run are factors that would differentiate a care co-operative from most other employers.

The viability of care co-operatives could also be undermined by scale and associated capacity constraints. The tendency for co-operatives to operate at small scale within communities was particularly attractive to focus group participants. However, small independent providers are at a disadvantage in relation to costs and they experience constraints in their capacity to deliver services. This is especially so where the HSE's commissioning process favours organisations that can provide services across a large geographical area. In this context, co-operatives need to collaborate through federated or shared service structures, or other models that enable them to achieve the benefits of scale without compromising their autonomy and local embeddedness.

Supportive Ecosystem

If care co-operatives are to form part of the solution to Ireland's care sector challenges, it will require a supportive ecosystem to foster their propagation and development. Key elements of this ecosystem include raising awareness of the co-operative model among stakeholders, which is often low; supportive policy, regulation and legislation; access to finance, including government-funded stimulus programmes; dedicated co-operative advisory services; and organisations that will animate and facilitate the development, or champion the cause, of care co-operatives. Stakeholder organisations who could support these endeavours include co-operative advisory services, such as the Irish Co-operative Organisation Society (ICOS), along with credit unions and social finance organisations. With Government buy-in and appropriate resources, other enablers would include local development companies, and the Older People's Councils within each local authority area. Trade unions along with age and care advocacy groups are likely to be other interested allies.

Through legislation, regulation and policy, the State and its institutions can enable or hinder the development of care co-operatives. The proposed new co-operative legislation in Ireland may reduce some of the current perceived disadvantages of registering as a co-operative. New schemes to enable care co-operatives to access finance through credit unions may require negotiation and agreement with the Central Bank of Ireland. Initiatives such as community share offerings, which are not currently permitted in Ireland, would allow co-operatives to raise capital from individuals who wish to invest, not for speculative return but because they wish to support and advance the development of care co-operatives.

Most fundamental of all in relation to the State is its policy on the commissioning and organisation of care services. The need for a clear commitment from the State to funding and using care co-operatives was identified as critical to their development and longer-term sustainability. The allocation of personal budgets to those approved for home care, who wish to manage and organise their own care, would allow such individuals and their families to exercise personal choice and provide opportunities for care co-operatives to grow their business. This is only one possible component of the root and branch reform of the care system as discussed in the Recommendations section.

Recommendations

The contributions made by this research to the current debate and its recommendations are as follows:

1. Envisioning and Progressing an Integrated Care System

At the level of society, the research makes the case to **embed Ireland's care system within a socio-economic system such as partnerism that values and rewards care**. Partnerism (Eisler, 1987) offers a framework for making care relations visible and instilling the cultural values needed to develop an integrated care system in Ireland. According to Cultural Transformation Theory (Eisler, 2017), a transition towards partnerism and creating the desired care system can be progressed through the following four cornerstones on which social systems are built and maintained.

The first cornerstone of gender relations is key to an integrated care system because women are the default carers. Thus, **achieving gender equality is essential in order to elevate the status of care relations and thus care work within Irish society**. This will be evidenced by the appropriate valuing and resourcing of care by the State, and in a rising proportion of male caregivers in the both the private domain of the home and in public domains into future generations.

The second (and expanded) cornerstone of community/family/childhood relations recognises that, firstly, home is where our beliefs and behaviours around care are first modelled and learned, and secondly, communities are the social fabric within which families are interwoven. Social capital is a measure of community relations or 'community spirit'. It is the sum of all local relationships of mutual aid and therefore represents a key asset in community-based care. If the State recognises the importance of social capital for an integrated care system, it will proceed to **(1) strengthen the social fabric of communities through policies that halt and reverse the centralisation of services and (2) appropriately invest in community development to enable community-led innovation in care provision**. One community-led innovation envisioned in this study is the creation of public spaces of care e.g. an open-door venue at the heart of a community. It could entail **reimagining and redesigning community centres to be universally accessible, multi-functional and inter-generational spaces that nurture care relations across the lifecycle**.

A socio-economic system that appropriately values and rewards care will appropriately resource it, and that represents the third cornerstone of economic relations. '**Doughnut economics', which envisages a 'safe and just space for humanity' within a 'regenerative and distributive economy', is proposed as a model for the type of economic relations required to recognise care jobs as green jobs and to bring about an integrated care system in Ireland**. An integrated care system would be designed to achieve four essential outcomes: (1) appropriate care for older people, (2) appropriate financial and other supports for family carers, (3) appropriate pay and conditions for care workers, and (4) a care system that distributes by design the benefits of care work to all those who co-produce care. This lies in stark contrast to the increasingly marketised home care sector where the wealth created is siphoned off to return a profit to investors.

The fourth cornerstone of narratives and language serves to make visible and celebrate the importance of care relations in all of human flourishing. Until such time as there is a renewed appreciation for the value of care in society, the lack of joined-up thinking and

practice by the State will continue to manifest as barriers for older people to age in place, ranging from obstructive bureaucracy and the narrow medical model of home care to the lack of a continuum of care between the homeplace and the nursing home. Instead, **adopting a worldview that embraces more holistic and symbiotic systems-based thinking, values multi-disciplinarity and takes a life-cycle approach for a continuum of care will be necessary to create an integrated care system**. Being integrated, the care system envisaged would not only serve older people, but ultimately all children, along with people who are living with disabilities or complex needs across the lifespan as well. Focusing on home care, the system would include (1) a social model of home care at household level with the adaptability to respond to diverse circumstances and environments, and (2) interwoven public sector strands (such as local planning to ensure a diverse range of housing stock) at community level. Successfully delivering home care within a more integrated or 'relational' system calls for ways of working and types of organisational models that are less hierarchical and more inclusive and collaborative. A well-established example in the care sector internationally is the care co-operative model.

2. Putting Care Co-operatives on the Agenda

A prerequisite to the development of care co-operatives in Ireland is the **need to raise awareness of the model** and how it could be applied to the societal challenge of providing high-quality care to an ageing population, and indeed to others who need care. This requires engagement with stakeholders, including statutory organisations responsible for organising and providing home care support, professional and family caregivers and care receivers, and communities. The wider co-operative sector could play a key role in awareness raising. Ireland has long-established and newer co-operatives in a range of sectors, most notably agriculture, financial services, and rural and community services. Well-established, trusted co-operatives, co-operative networks and representative organisations would provide a credible channel for communicating the co-operative model. Reaching the target audience could be critically dependent on collaboration with trade unions, age advocacy and carer advocacy groups, local authorities, local development companies and community groups.

Any campaign for awareness-raising and communication should be conducted as an **interactive, multistakeholder dialogue**. Since the sustainability of co-operatives relies on the support of a group that coalesces around a bottom-up initiative, care co-operatives only provide a solution where there is sufficient stakeholder 'buy-in'. Part of the dialogue will involve **an exploration of the appetite among care recipients, family carers, care workers and other interested parties to become involved in starting and actively sustaining engagement in care co-operatives**. It will also entail assessing whether there would be a critical mass of care workers sufficiently motivated by the rewards to invest their time and energy, particularly in the adoption of innovative approaches, such as organisational democracy and self-management.

Care co-operatives offer potential solutions to the problems of 'conveyor-belt care' highlighted by participants in this study. The concept of 'design for use' rather than for profit, and the opportunities for co-designing high-quality care, empowers those receiving care and family carers to influence how older age is experienced. Furthermore, by improving working conditions, care co-operatives can help to address the lack of capacity in the home care sector due to inadequate labour supply. The potential for stakeholders to work collectively to solve such problems should be of interest

to statutory organisations with responsibilities for home care provision. Therefore, the concept of care co-operatives needs to form part of a national social dialogue on care. The Commission on Care for Older People, set to commence its work in 2024, represents a key opportunity to introduce care co-operatives to this dialogue and onto the policy agenda, perhaps using this report as a launchpad for such a discussion.

3. Developing a Supportive Ecosystem for Care Co-operatives

The development of care co-operatives requires an appropriate institutional framework to support emerging co-operatives in their endeavours.

There is a need for **a dedicated co-operative advisory service** to offer guidance, act as a repository for learning, and avoid duplication of effort and repeated mistakes that would likely occur in a fragmented movement of groups working in isolation. This might be a new organisation or, more likely, particularly at the early stages, a unit within an existing co-operative support organisation, such as the Irish Co-operative Organisation Society (ICOS). **Collaboration with statutory organisations, such as the HSE, and with social finance organisations, would be key to providing a comprehensive, dedicated service to support care co-operatives to navigate the legal, regulatory and bureaucratic systems, develop appropriate structures and rules, devise feasible business models and access funding.**

Groups intending to form a care organisation based on the co-operative model should give due consideration to registering as co-operatives. Proposed changes to legislation are likely to make registration and compliance less burdensome than under the current legislation. **Appropriate structures and rules are essential to support the democratic structure and process at the heart of co-operative governance.** As a further enabler of co-operative action, and to safeguard the integrity of the co-operative model, **education and training** are required to support the elected co-operative officers to perform their roles effectively and to foster democratic governance and participation by members.

This report has highlighted two care co-operative ownership models – the multi-stakeholder model and the worker co-operative model. By its nature and composition, the multi-stakeholder model is more complex. However, it offers a more formal structure for the needs of care recipients, their advocates and care workers to be well represented. It also offers opportunities for public sector organisations to play a more active, embedded role in co-operatives, with limited voting rights.

As a highly regulated sector where access to clinical governance expertise is essential and, under the current system, capacity to deliver services across a defined area is essential, **scale is a key consideration for emerging co-operatives. One possible model is the gradual scaling up of an existing co-operative by adding new local hubs, as demonstrated by the Great Care Co-op.** This model offers a way for co-operatives to extend their services to several areas rather than starting new co-operatives in each community. **An important consideration in the scaling process is to maintain equitable representation and embeddedness in the various communities served** e.g. through a federated model. Such a model would allow local co-operatives to maintain their independence and autonomy while benefitting from shared services that enable them to meet compliance requirements and achieve efficiencies.

This report has highlighted the many advantages offered by care co-operatives in terms of empowering those who give and receive care. However, it cannot be assumed that co-operatives inherently provide better working conditions and/or a better service for clients. **Additional training is required to equip care workers with the skills and knowledge required to adopt innovative work practices, such as those implemented in care co-operatives encountered in this study, and to provide safe, high-quality care.**

The development of a **State-funded pilot programme to co-design and develop prototypes of community-led care, in partnership with relevant statutory organisations,** would provide an opportunity to give practical expression to the principles of partnership between the Health Services and the voluntary sector, as set out in the Health Dialogue Forum (2023).

More research is needed to **deepen learning from international experiences of care co-operatives** working in collaboration with public sector partners. In particular, there is a need to learn about the **challenges of maintaining organisational autonomy and resisting cultural assimilation** when co-operatives become part of a care system that remains characterised by predominantly efficiency-driven, one-size-fits-all, hierarchical relationships. This autonomy would include the freedom to deliver care equitably in a way that is compliant with regulation but is co-designed by care workers, care receivers and their advocates, regardless of whether care is provided directly to private clients or on behalf of statutory care commissioning organisations. Just as importantly, it would safeguard the capacity to provide excellent working conditions for care workers.

1 Introduction

Research on the residential preferences of older people in Ireland (O'Sullivan, et al., 2022) and elsewhere indicates that older people have a strong preference to remain in their own homes or, atleast, in their own communities, rather than institutional settings such as nursing homes, for as long as possible (Wiles et al., 2011; WHO, 2020). Many people in older age need care and support to enable them to remain in their own homes. People aged 80+, or the "elder elderly", as described by Schultz et al. (2015, p.44), are more likely to have complex care needs (OECD, 2020). While family members are the main providers of care in Ireland (Keane et al., 2022, p.5), professional home care is an essential service for many older people. This may be particularly important for the approximately 63% of people aged 80+ who live alone (Barrett and Kelly, 2016). Estimates (based on 2019 data) suggest that almost 65,000 people aged 65+ received home care annually. Of these, almost 39,000 availed exclusively of the public home support scheme funded and organised by the Health Service Executive's (HSE) Older Persons' Services; 14,200 supplemented this with privately contracted services; and 11,600 relied exclusively on privately contracted care (Walsh and Lyons, 2021).

In the intercensal period 2016-2022, a 26% increase in population was recorded in the 70+ age-group, rising from 426,331 to 538,171; within this age group, the number in the 85+ sub-group increased by 25% from 67,555 to 84,441.[1] Recent population projections for Ireland indicate that, by 2051, the 70+ age-group is projected to more than double to almost 1.2 million, while the 85+ age-group will almost quadruple to 304,900[2] Meeting the care needs of this ageing population in a way that respects older people's rights and supports them to experience the best quality of life possible, presents a significant challenge for Irish society.

Despite an increased budget for home care services in recent years, during 2023 up to 6,400 people approved for home care (including new clients and existing clients approved for additional hours) were waiting to receive these services.[3] Difficulties experienced in attracting workers into the care sector, and retaining existing workers, constitute a key impediment to the delivery of home care. A stakeholder consultation undertaken by the Department of Health in 2021 highlighted a wide range of challenges impacting recruitment and retention (Department of Health, 2022). Among the key considerations in terms of recruitment were: an inadequate supply of suitably qualified care workers; an ageing workforce (63% of home support workers were aged 55+, highlighting future challenges due to retirements); and the view that care work is "unattractive, poorly remunerated, and under-valued" (ibid., p.9). Poor pay and conditions, precarious contracts, employment competition from other sectors (e.g.

[1] Census of Population 2022 (Central Statistics Office, https://www.cso.ie/en/releasesandpublications/ep/p-cpsr/censusofpopulation2022-summaryresults/populationchanges/)

[2] CSO (2018) Population and labour force projections 2017-2051. https://www.cso.ie/en/releasesandpublications/ep/p-plfp/populationandlabourforceprojections2017-2051/populationprojectionsresults/

[3] As reported by Bernard Gloster, CEO of the HSE, to the Oireachtas Committee of Public Accounts, 11 May 2023. https://www.oireachtas.ie/en/debates/debate/committee_of_public_accounts/2023-05-11/5/?highlight%5B0%5D=emergence

retail), and lack of career development opportunities are among the numerous factors negatively impacting retention of workers.

An increase in the proportion of care hours outsourced by the HSE through a competitive tendering process has provided business opportunities for private care companies. It is acknowledged that private care companies are not a homogenous group; in addition to large multinational chains, there are also some family-owned small businesses and micro enterprises). However, amid this diversity, there is a strong trend towards the "market concentration and the consolidation of ownership amongst the big multinational chains" (O'Neill et al., 2023, p.30). For these businesses to be commercially viable, they must be able to extract a profit for their investors. Some of this profit may come at the expense care workers, whose pay and conditions compare poorly to care workers employed directly by the HSE. The decline in the numbers willing to work in the care sector presents significant challenges for meeting the future care needs of Ireland's steadily rising older population. This calls for innovative solutions that can help to attract committed workers into the sector by truly valuing and appropriately rewarding care work.

1.1 Study Aims and Objectives

This report represents the culmination of **the CO-AGE project**, which sought to explore the co-operative model of home care provision and considers its potential to be developed in Ireland. Cooperatives are "people-centred enterprises owned, controlled and run by and for their members to realise their common economic, social, and cultural needs and aspirations" (International Cooperative Alliance, n.d. a). Unlike businesses that are motivated by profit, co-operatives are driven by values of democracy, self-help, self-responsibility, solidarity, equality and equity.

The study focused on addressing three key research questions:

1. To what extent is there interest among stakeholders in establishing home care co-operatives in Ireland?
2. What practical and policy supports are needed to facilitate the establishment of such co-operatives?
3. How can existing knowledge and expertise within communities and the co-operative sector be leveraged to support the development of these co-operatives?

The report includes brief case studies of two care co-operatives to illustrate how the co-operative model can be applied in the care sector. Through focus groups, we hear the voices of care workers, family carers, people who are interested in planning for their own future care needs, and representatives of key organisations and sectors that could potentially support the development of care co-operatives in Ireland.

1.2 Structure of the Report

Chapter 2 draws on literature to examine the concept of care and considers who provides care. It examines how home care policy and practice in Ireland have evolved in the context of economic and cultural models that have tended to 'dehumanise' care. The concept of the care co-operative model and its potential to 'rehumanise' care is explored. An overview of international examples of care co-operatives is provided, and brief case studies of two existing care co-operatives, one in Ireland and one in England, are included.

Chapter 3 outlines the methodology employed in the study.

Chapter 4 draws on accounts from focus group participants to explore the lived experience of people who have interacted with the care system in Ireland, whether as care recipients, people planning for future care needs, family caregivers, or care workers. It outlines what individuals want in their older age, along with the roles that households, communities and wider society, including the State, play in care of older people in Ireland.

From the focus group discussions, there emerged a significant desire for a different care system. This provides the wider contextwithin which the model of care co-operatives is explored in Chapter 5. This chapter considers the potential of the co-operative model to create a care system that works betterfor care workers and care recipients. It also acknowledges the limitations to innovation that care co-operatives may experience in the context of their integration into the wider conventional care system. Matters around co-operative set-up, registration and viability, which need to be considered by any groups intending to form care co-operatives are discussed. This is followed by an in-depth consideration of the wider ecosystem that influences the establishment and sustainability of care co-operatives. Chapter 6 summarises key findings and provides recommendations for the development of a more partnership-based care model, with care co-operatives as a key partner.

This research was enabled by funding from the Irish Research Council's New Foundations scheme, which supportscollaborative research between academic researchers and the community and voluntary sector. This project is the result of a collaborative partnership between the Centre for Co-operative Studies, University College Cork, and Age Action Ireland. However, research analysis, key findings and any opinions expressed are those of the researchers and should not be assumed to reflect the position of Age Action.

2 Understanding Care: Theory and Practice

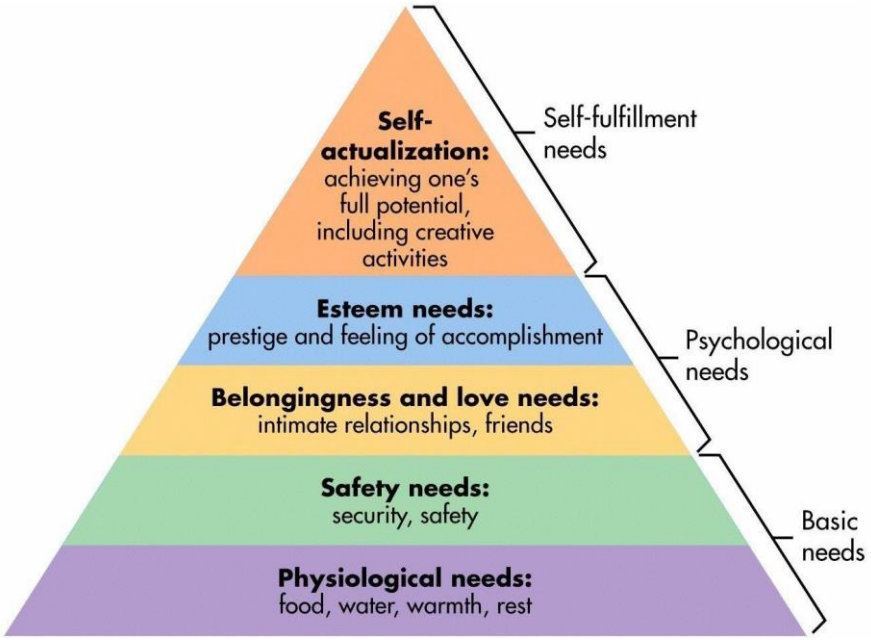
2.1 Introduction

This section sets out the 'what', 'who' and 'how' of care. It first assesses what we mean by 'care' before turning attention to the people who provide care, along with the policies and practices that have emerged around home care in Ireland. It then examines the relational dimension of care, which highlights the interdependence of people as givers and receivers of care through the life cycle. The cultural and economic models in which care is currently embedded are explored, highlighting an undermining of the relational dimension and the 'dehumanisation' of care. From there, we assess how a collective approach, specifically through the co-operative model, can 'rehumanise' care. Discussion focuses on the key characteristics that differentiate co-operatives from conventional, for-profit businesses. Irish and international examples of care co-operatives are considered and case studies of two existing care co-operatives are outlined.

2.2 What is 'Care'?

Maslow's (1943) hierarchy of needs summarises the range of human requirements across the lifespan (Figure 2-1). Basic needs include food, warmth and safety. Psychological needs include close relationships and feeling a sense of achievement. These are essential to a good quality of life throughout one's life, including in later years.

FIGURE 2-1: MASLOW'S HIERARCHY OF NEEDS.



Source: McLeod, 2018.

People's needs and their ability to meet them vary according to individual factors such as physical, mental and intellectual capacities and health status. Individual factors are in turn shaped within households and communities by education, income and/or class and more widely by political and cultural influences ranging from ideologies (e.g. religious, political, economic) to their tools of implementation (e.g. doctrine, policy, legislation, regulation, etc.), all of which circumscribe how people might meet their needs.

Aside from the individual factors that influence how we meet our needs, people live in states of interdependence through their relationships with one another. Care is relational, and giving and receiving care is central to meeting our needs and to others meeting theirs. Lynch (2021) describes the relational life as the work of creating humanity and considers that care and love are fundamental to the production of life in all its forms. According to the European Foundation for the Improvement of Living and Working Conditions, care is defined as "the provision of what is necessary for the health, welfare, maintenance and protection of someone or something. It includes childcare, long-term care of older persons or those with disabilities, and healthcare" (Eurofound, 2023).[4]

All human relationships exhibit elements of dependency, with some kinds being more visible or more stigmatized than others. The most dependent humans are babies and toddlers, along with children and adults with complex needs. Their very survival depends on receiving care. Others who may have difficulty meeting their own needs adequately and thus have more discernible dependency on sustained care include those suffering from ill-health or with particular physical or psychological conditions. Advocacy groups such as Age Action highlight that such dependency in the case of older people is at least partially rendered by a socio-economic system that has not been designed to optimise their autonomy within a relational framework.

Optimising autonomy in older age calls for a continuum of supports that can respond appropriately as people's circumstances change over their lives. In terms of housing, for instance, some people may need particular supports to remain in their own homes, such as home adaptations, home care and repair, assistive technology, and home care services. Rather than adapting their existing home, others may consider moving to a more suitable dwelling. Some with higher levels of dependency may need to move to supported housing or nursing homes (Cullen et al., 2007). In the absence of a continuum of appropriate and enabling supports across the life cycle, people's capacity to meet their needs with or without the care of others is likely to be constrained.

2.3 Who Cares?

The people who care for others are known as 'carers' (in Ireland and the UK) or 'caregivers' (in the US). Caring (or caregiving) is the act of providing care. It may be unpaid care by family, friends or neighbours (this is also referred to as informal care) or it may be paid care by care workers (formal care) (Li and Song, 2019). In Ireland, someone who provides unpaid care is called a 'family carer'.

It is incumbent on society to care for carers (both family carers and paid care workers) and enable them to meet their needs. For instance, in recognition of the negative impact of caring duties on carers' livelihoods, family carers are eligible for a social welfare payment from the State.[5] The 'carers allowance' is a means-tested payment available to family carers on low income, while the 'carers benefit' is paid to those who leave work or reduce their hours in order to care. However, Family Carers Ireland (2023) has flagged limitations with these income supports, describing them as inadequate, gender biased and overly restrictive, including for carers seeking to also participate in other work or education.

[4] https://www.eurofound.europa.eu/en/topic/care.

[5] See: www.citizensinformation.ie for more information.

Paid care workers engaged in formal care may be employed in the public, private (for-profit) or community and voluntary sectors. Currently, Ireland is experiencing a significant shortage of people who are willing to work in the care sector. This, together with other issues in the care sector, is outlined next in Section 2.4.

2.4 Home Care Policy and Practice and Neoliberal Capitalism

In Ireland, home care or home support follows "a family-based structure", where family members are the main providers of care (Keane et al., 2022, p.5), supplemented by care provided by the State or privately procured care services. Census 2022 recorded an increase of 53% in the number of people providing unpaid care to a family member, neighbour or friend with long-term health issues, disability or issues related to older age (299,128 in 2022 compared to 195,263 in 2016) (CSO, 2023). There was also a significant increase in the number of unpaid care hours provided over that period; the proportion of carers providing 43+ hours per week increased from 21% in 2016 to 29% in 2022 (ibid.).

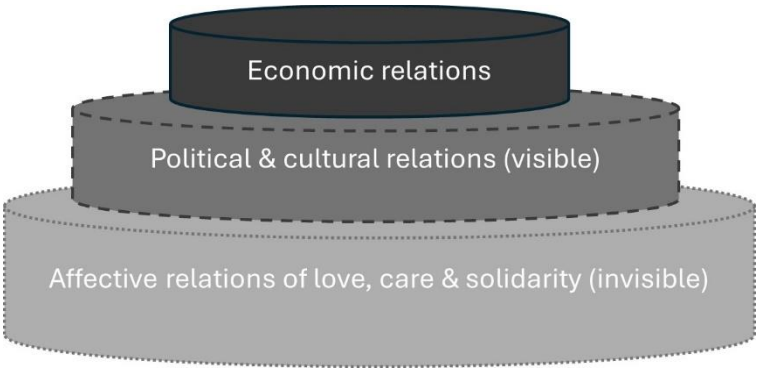
The Department of Health's Sláintecare health reform programme commits to providing care in thecommunity setting, including home care, to enable people to live well within the community, only resorting to institutional settings, such as nursing homes, where necessary. However, while a statutory entitlement to nursing home care was introduced in 2008 (known as the 'Fair Deal'), it is only since the 2020 Programme for Government that work has commenced on the development of a statutory home support scheme, which aims to provide equitable access to regulated home care based on assessed needs (Walsh and Lyons, 2021). While the scheme will provide a right to assessment, it is likely that capacity constraints, particularly care workforce shortages, will mean that a right to home care cannot be guaranteed. As part of the statutory home support scheme, financing models for home care are being explored. Currently, publicly funded home support for older people is provided free of charge through the HSE budget. The level of support provided is based on an assessment of the individual's care needs. However, the extent to which these needs can be met on an individual basis is dependent on the provision of adequate exchequer funding and the availability of a supply of suitably qualified care workers.

The current failure to deliver approved care hours to over 6,000 people is attributed to recruitment and retention challenges, which have led to a shortage of care workers (Department of Health, 2022). Poor pay and conditions, precarious contracts, employment competition from other sectors (e.g. retail), and lack of career progression opportunities mean that care work is not generally viewed as an attractive career. These challenges are compounded by an ageing workforce. HSE data from 2021 indicate that 63% of home care workers were aged 55 or over and, therefore, significant numbers of such workers will be lost to the sector through retirement in coming years (ibid.).

This shortage of care workers is an outcome of how society values and rewards the work of care in general. Lynch (2022) has highlighted that such negative outcomes are underpinned by inequalities that are generated across the interacting economic, cultural, political and affective systems, which undermine capacities and resources in each other. These systems vary in their visibility, ranging from the most visible system of economic relations to the invisible system of affective relations (e.g. relations of mutual support and care). According to Lynch (2022), the dominance of economic relations in society has rendered them the driving force in the development of the care system (Figure 2-2).

The Irish State became involved in providing home care in the mid-20th century. Much of this care was provided by voluntary and religious organisations that were funded by the State. The dominance of these organisations as care service providers was particularly pronounced in the Dublin region, whereas care services provided directly by the State were more common in the rest of the country. Private care providers emerged in the 1980s, particularly in the Dublin region, where they eventually displaced many voluntary and religious organisations (Mercille and O'Neill, 2021; 2022). However, voluntary organisations are still an important component of the care system, and some receive funding from the HSE under Section 39 of the Health Act (2004), hence the common reference to these as Section 39 organisations.

FIGURE 2-2: DOMINANCE OF ECONOMIC RELATIONS IN THE CURRENT CULTURE.



Adapted from: Lynch (2022).

In the 1990s, there was a gradual but increasing marketisation of home care services, characterised by outsourcing to a growing private sector and the application of business principles to public service delivery (Cullen, 2019; O'Neill, 2020). Growth of the private sector gathered momentum and began to spread beyond Dublin during the later Celtic Tiger period (mid-2000s), when public expenditure on home care grew but work was increasingly outsourced to private providers (Mercille and O'Neill, 2021; 2022).

Outsourced care gradually eclipsed the direct provision of care by HSE employees, especially in the period of austerity that followed the economic recession of 2008. Cuts to public spending led to underinvestment in the public sector's direct provision of home care, and recruitment embargoes meant that staff leaving due to retirement and other reasons were not replaced. This resulted in the simultaneous "hollowing-out" of the HSE's capacity for direct provision of care (Mercille and O'Neill, 2022, p.9) and the creation of ideal conditions for the rise of the for-profit care providers, especially multinational corporations. These trends evidence the influence of neoliberal capitalism on the provision of home care in recent decades as the State combined limited investment in public services with the reassigning of welfare, including care services, increasingly to the private, for-profit sector (Lynch, 2021).

The introduction of competitive tendering in 2012 provided opportunities for commercial operations to flourish (Cullen, 2019), particularly as they were better equipped than the non-profit sector to compete in the HSE's tendering process (O'Neill, 2020). This tendering process has been a key factor in the growth of the private sector. The dominance of the for-profit sector is significantly more pronounced in the Dublin region but has spread to other cities and larger towns. For-profit companies prefer to operate in areas where there is a significant concentration of potential clients; they have been less inclined to

operate in rural areas where it proves more difficult to hire care workers who will travel significant distances between clients without being paid for travel time (Mercille and O'Neill, 2022).

Whereas the HSE was once the main provider of home care services, it is increasingly a commissioner of these services in what Cullen (2019, p.7) describes as "a dense web of State, non-profit and private organizations". As of May 2023, just under 38% of publicly funded home care was provided directly by HSE-employed health care assistants, while over 62% was provided by for-profit and non-profit organisations contracted or funded by the HSE to deliver care on its behalf.[6] Economic and Social Research Institute (ESRI) estimates for 2019 indicated that the majority of commissioned care was provided by for-profit businesses, whose allocated home care hours outnumbered the non-profit sector by a ratio of approximately 7 to 1 (Walsh and Lyons, 2021).

O'Neill et al. (2022, pp.19-20) point to a significant body of international literature that suggests a deterioration in home care employment conditions linked to "marketisation reforms, cost-cutting policies and New Public Management (NPM) – which aims to make public services more 'business-like and efficient by using private sector management models'". Lynch (2021) concurs that poor employment conditions in the care sector reflect the institutionalisation of market-based cultural logics and values throughout public services (as well as in voluntary and community organisations and even in personal life).

The results of a survey of home care workers in Ireland suggest that "marketisation degrades the working conditions of care workers, with lower labour costs (through savings on contracts, pensions, pay and benefits) acting as a source of profit for private care providers" (ibid., p.29). In other words, the private model of home care provision appears to prioritise its relations with private investors over and above those with its care workers. Meanwhile, the unique cultural logic of neoliberal capitalism undermines the values that draw people into care work in the first place (Lynch, 2022). The resulting shortage of care workers impacts older people's access to care and the quality of care, impacting on them and their family carers. For instance, a survey by Family Carers Ireland (2022) found that one-in-four family carers experienced either delays in accessing home care or a reduction in care hours, both attributed to a shortfall of home care workers.

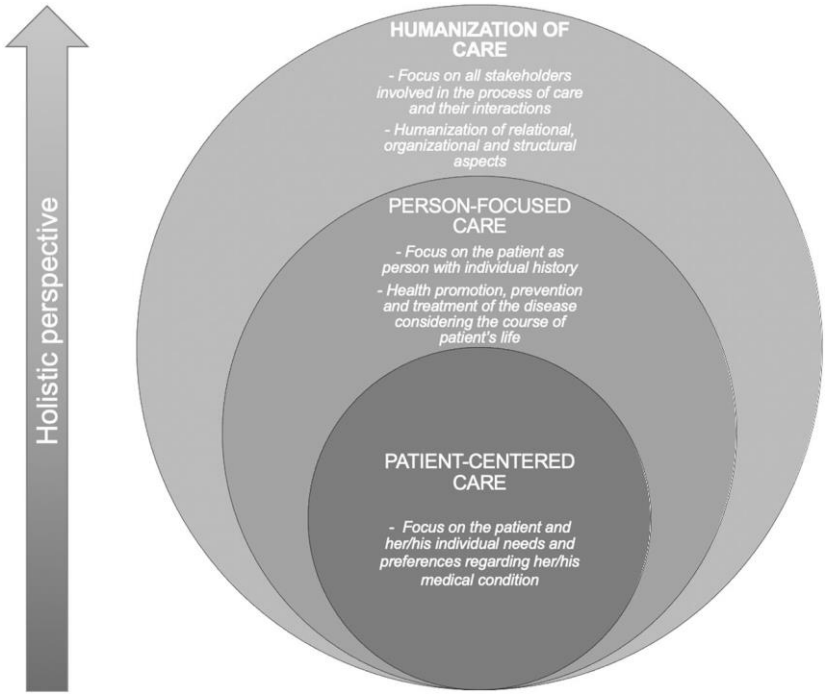
2.5 The Significance of Relationships in Care

In a webinar organised as part of the CO-AGE project, Emma Back, founder of Equal Care Co-op in Yorkshire, summarised changes over time to the prevailing model of care in the UK. Up to the 1990s, the care and support paradigm was institution-centred, where business logic was to the fore, organisation was hierarchical, user needs were stereotyped, responses were universal, negotiation was adversarial in cases of differences of opinion, and the person was "expected to conform to the system" (Back, 2022). Progress has been made towards a more personalised, co-ordinated and empowering care model that is person-centred, focused on individual needs and customised responses. While recognising the care recipient, the person-centred model still does not foreground the human relations with care givers that are intrinsically

[6] Based on correspondence with the HSE, June 2023.

important to the experience of giving and receiving care (ibid.). The care relationship "involves compromise, it involves consent, and it involves give and take" (ibid.). Responding to these perceived deficiencies in the current care system, a relationship-centred model of care is emerging through grassroot initiatives (such as Equal Care Co-op) that consider power dynamics and reciprocity among stakeholders. Such a relationship-centred model indicates a shift towards the humanisation of care, as synthesised in Busch et al.'s (2019) systematic review (Figure 2-3). However, meaningful relationships take time and attention, two properties in short supply among stressed workers under extreme time pressure (ibid.).

FIGURE 2-3: DEVELOPMENT OF RELATIONSHIP-CENTRED CARE (OR THE HUMANISATION OF CARE).

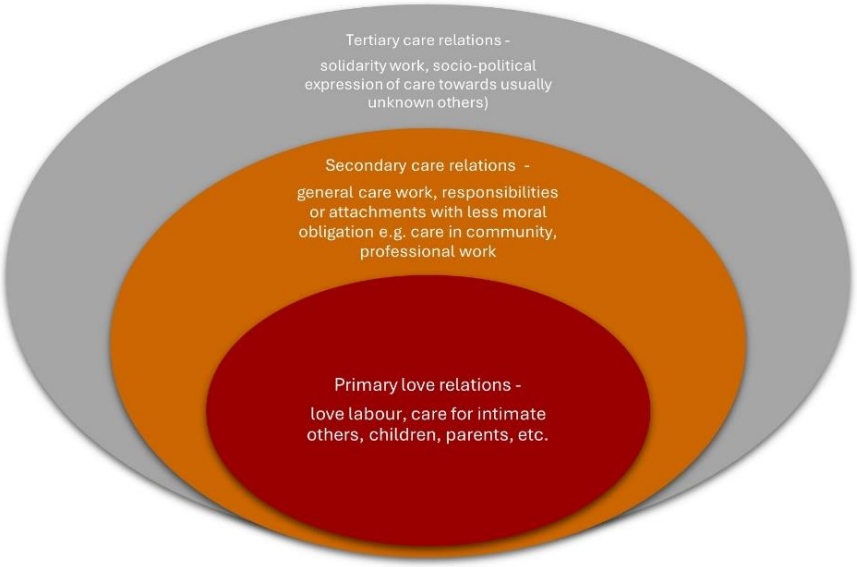


Source: Busch et al. (2019, p.462).

2.5.1 Understanding Care Relations

Lynch (2021) describes three different levels of care or affective relations depending on the nature and strength of the relationship under consideration: primary (or 'love'), secondary (or 'care') and tertiary (or 'solidarity') (Figure 2-4). Family carers are found in the primary care relations of intimate partners or relatives. Care workers are examples of secondary care relations, providing care on a professional basis, while those involved in advocacy can be seen as people engaged in tertiary care relations. Women tend to be society's default carers, especially at the primary and secondary levels but often in the tertiary level too. And Lynch argues that affective relations involve work, are productive and, where lacking, result in negative outcomes such as poor health or poverty.

FIGURE 2-4: THE THREE LIFE-WORLDS OF LOVE, CARE AND SOLIDARITY.



Based on Lynch (2021; 2022).

Such relational work of love, care and solidarity is fundamental to human existence as it "produces people mentally, emotionally, socially, politically and economically" (Lynch, 2022). Yet, why is care work defined as low-grade work in the dominant system of economic relations? Capitalist society, driven as it is by the demands of accumulation, privileges production that is oriented to exchange, such as in the marketplace, rather than simply for use or provisioning. Since most care work creates a use value, rather than a marketable exchange value, it can be dismissed as "natural work" that falls to humanity's carers, predominantly women (ibid.). Consequently, despite being fundamental to life, the care of others (together with community volunteering and nature's ecosystem services) is taken for granted. Capitalism sees no obligation to support the fundamental contributions of care, which it does not define as "real work". The corollary of this is that care work is neither valued nor rewarded appropriately - politically, culturally or economically. Another view of care is as a 'gift', something that is given without any guarantee of a reward. Thus, once care relations become commodified as care work in a capitalist economic system, where its "social use value is not represented by its exchange value", it leaves "the burden of care to be undertaken by poorly paid women" (Goodman, 2016, p.332-3) or by those from other marginalised groups. The implications that this value system has for the economics of care are considered next, along with an alternative value system that offers a pathway towards a more caring economy.

2.5.2 Bringing Care Relations and the Care Economy Together

Capitalism builds on and reinforces pre-existing hierarchical, patriarchal and racist systems that perpetuate and deepen inequalities, resulting in much human suffering and the weakening of democracies and communities (Lynch, 2022). According to Lynch (2022), the "morality of capitalism" validates ambition and competition as virtues, while neoliberal capitalism endorses a non-relational, self-referential, entrepreneurial individualism *in particular*. These are the "desirable traits" which underpin the culture and politics of neoliberalism, and have become our worldview, not only in the public domain of capital-labour relations in the economy but also in the private domain of "affective relational life" (ibid.).

However, despite capitalism's reach into even our affective relations of love, care and solidarity, care remains "a central cultural consideration internationally" (Lynch, 2022). It exists as a "care consciousness" that survives as a "residual cultural practice" in the "cultural and political underground". As such, Lynch continues, the cultural practice of care could be "enabled, resourced and endorsed to actively contest the values and practices of neoliberal capitalism". This is the basis on which people might be enabled to "move beyond capitalocentric thinking, if their care lives and concerns are allowed to move from being dishonoured to being named and claimed as political and public issues" (ibid.). In order to reorient from the notion of 'the competitive individual' towards a relationship-centred understanding of the human being instead as an interdependent giver and receiver of care, Lynch (2022) calls for a political and cultural appreciation of the self as co-created, and thus recognition for the importance of affective relations of care across the lifespan and in all areas of life. Care co-operatives have been responding to the erosion of a care consciousness by harnessing the residual cultural practice of care, bringing care out of the cultural and political underground and helping to make affective relations visible again so that they may be recognised and appreciated in wider society.

To help with reimagining a socio-economic system in Ireland that would value and reward care, Dr Riane Eisler's systems-based overview of the social scale configuration offers an international perspective. In her work, Eisler (1987; 2017) critiqued the conventional binaries of social organisation thinking such as capitalist and socialist, rightist and leftist, Western and Eastern, religious and secular, and so on. She concluded that regardless of political, religious or economic ideologies, what actually distinguishes systems of social organisation is how their beliefs, relationships and institutions are structured along a continuum of configurations ranging from 'partnership' to 'domination'. She set out her findings as Cultural Transformation Theory (CTT) (Eisler, 1987; 2015). In light of CTT, Eisler called for the study of relationships using a systems approach. This, she argued, would reveal the various tiers of human relations, from interpersonal to local and national, from the private to the public domains, and show how different parts of a social system or culture interacted to shape and maintain each other and the system (Eisler, 2017). Out of this research, Eisler went on to describe a new and hopeful socio-economic system called 'partnerism' based on relational dynamics that are designed to nurture humanity. Table 2-1 shows the contrasting characteristics at both ends of Eisler's partnership-domination social scale.

TABLE 2-1: THE PARTNERSHIP AND DOMINATION SOCIAL SCALE.

Partnership	Domination
• Everyone matters	• In groups and out groups
• Hierarchies of actualization	• Hierarchies of domination
• Increase in liberty and expression	• Power maintained by force and fear
• Equality: gender, race, etc.	• Inequality
• Care is valued economically	• Ignore economic value of caring
• Human flourishing and creativity	• Violence and abuse

Adapted from: Center for Partnership Studies (2022).

Due to its inclusive focus on both human capacity and social capital, partnerism offers a helpful overarching schema within which to consider the provision of home care in Ireland.

Eisler and Fry (2019, p.170) noted how studies on health and wellbeing showed the benefits of partnership systems "for individuals, families, communities, and nations" compared with domination systems and "their dehumanizing and destructive features". Cultural transformation theory has already been used to assess and advocate for positive cultural change in services such as healthcare and policing in the US (e.g. McKee and Lewis, 2016). Kennedy Oehlert (2015) applied the partnership-domination continuum in her research with healthcare leaders as a foundation for understanding the American healthcare culture. She found that healthcare tended towards domination (e.g. a rigid leadership hierarchy, fear of reporting errors, bullying, failure to value patients' voice and paternalism) rather than partnership (expertise recognised at all levels, including that of patients). The domination configuration in that healthcare system resulted in negative impacts on patient safety and quality of care, and on the employee and patient experience. She recommended using CTT to help healthcare leaders to identify domination patterns in their organisations in order to foster relationships of partnership instead.

At the broader level of the socio-economic system, Eisler (2012, p.59) considered "that the failure to recognise the real value of the work of caring and care giving has been a major obstacle to the development of a more equitable and sustainable approach to economics". If the socio-economic system fails to value care and its importance to society, it follows that it will fail to value care work and appropriately invest in its care system. It will fail to see care as a social investment with a high level of return in terms of women's employment and socio-economic wellbeing (Barry and Jennings, 2021). In response, partnerism challenges the dominant economic theories of both capitalism and socialism, which Eisler argues only recognise a distorted economy with three economic strands: the Market Economy, the Government Economy and the Illegal Economy. An innovation of partnerism is that it outlines three additional strands in the 'real' economy that are vital to achieve more equitable and sustainable development, namely:

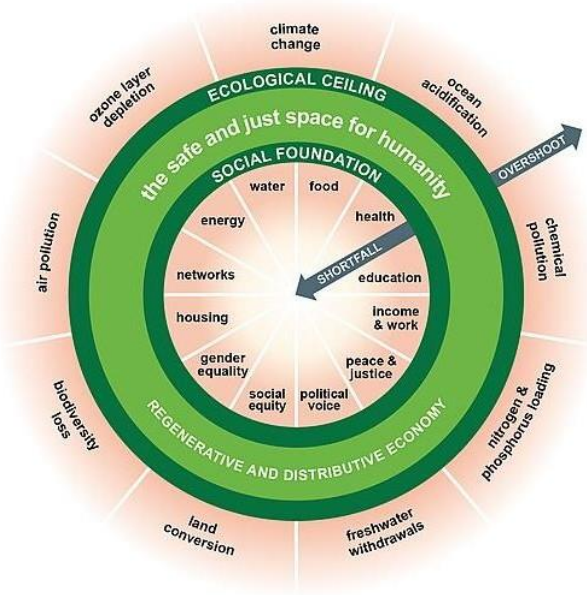
1 the Household Economy.
2 the Unpaid Community Economy, and
3 the Natural Economy.

Together, these three additional strands make up the 'care economy' (e.g. Dukelow et al., 2024). The household economy represents all the productive labour of raising children, sustaining the labour force, caring for the vulnerable, including older people, and maintaining healthy home environments, all of which underpin human capital. The unpaid community economy comprises the work and care of community-based volunteers who add incalculable value to the social fabric and local economies of communities, as measured by social capital. The natural economy represents the unaccounted-for value of inputs from the environment and biodiversity that comprise the living systems and natural resources essential for human flourishing, known as natural capital. The first two strands are significant in terms of valuing and rewarding care provided for people at home and within communities, while the third represents the ultimate care provider, nature, within which health and social care are embedded.

Not only is nature essential for social care, but there is mounting awareness since the COVID-19 pandemic that care jobs are 'green jobs'. The average job in social care results in much lower greenhouse gas emissions when compared with e.g. the average manufacturing or agricultural job (Diski, 2022). Thus, public investment in social infrastructure to improve the quality and extent of care would also serve as a response to the need for achieving climate justice under the European Green Deal (Diski, 2022; Dukelow et al., 2024). The recognition and successful integration of the three strands of productive care work into the 'real' economy are dependent on a society having a cultural value system that orients to a partnership configuration. According to Eisler and Fry (2019, pp.160-1), the key values of a partnership socio-economic system are: "(1) overall egalitarianism[7]; (2) equality, respect, and partnership between women and men; (3) a non-acceptance of violence, war, abuse, cruelty, and exploitation; and (4) ethics that support human caring, prosocial cooperation, and flourishing". Such a system "values and rewards caring for one another, nature and our collective future" (Center for Partnership Studies, 2022).[8]

As well as an appropriate cultural value system, linking the care strands into the Irish economy in practice also calls for a model of economics that shares the values of partnerism and takes a more integrated approach than conventional models (e.g. Eisler, 2007; Eisler and Fry, 2019; Peeters, 2022). One such model that is gaining traction at organisational, community and regional scales internationally is 'Doughnut Economics'. It aims for an economy that represents "an ecologically safe and socially just space in which all of humanity has the chance to thrive" by integrating a social foundation with an ecological ceiling (Raworth, 2017a, p.48). Figure 2-5 visualises how this holistic model encompasses a systems approach that also speaks to the United Nations (UN) 17 Sustainable Development Goals.

FIGURE 2-5: DOUGHNUT ECONOMICS.



Source: Raworth.com.

[7] Seeking equality of outcomes.

[8] https://www.partnerism.org/

Developed by UK economist Kate Raworth (2017b), Doughnut Economics outlines an approach that may be suitable not only for designing a more integrated economy in Ireland but for creating a more integrated care system too. The following are her 'seven ways to think like a 21st century economist':

1. 'Change the goal' calls for a move from GDP to the Doughnut and meeting everyone's human rights (including in care-relevant factors such as social equity and health).
2. 'See the big picture' advocates for a shift from a circumscribed market to an embedded economy in service to society, where purpose comes before profit (and both households and communities are key tiers).
3. 'Nurture human nature' changes the focus from rational economic 'man' to relational beings, inter-dependent with one another and the natural world (including through relations of care).
4. 'Get savvy with systems' recognises the reality of the dynamic complexity of human systems rather than conventional economics' mechanical equilibrium (and thus the need for the national care system to reflect such dynamism and be open to its complexity).
5. 'Design to distribute' considers that inequality is a design failure, not an economic necessity, and therefore design must be distributive from the outset (including through sharing wealth with those providing care at household and community levels by appropriately valuing and rewarding their vital and productive work).
6. 'Create to regenerate' likewise calls for design that is regenerative or circular because humans are embedded within the cyclical processes of life on Earth - not apart from it (and this recognises the need for an integrated continuum of care across the entire human life cycle).
7. 'Be agnostic about growth' acknowledges that no system grows forever but rather goes through cycles (and thus the care system needs to be flexible to changing demand and supply in response to demographic trends from ageing to migration, rather than constrained by a growth-dependent extractive and profit logic).

Lynch's 'affective relations', Eisler's 'partnerism' and Raworth's 'doughnut economics' provide valuable frameworks for helping us to re-imagine a care system in Ireland underpinned by appropriate values (the why), models (the what) and approaches (the how) for a relationship-centred model of care, including for older people at home. The next section considers what type of organisation might be suited to these frameworks or capable of providing more relationship-centred care.

2.6 Rehumanising Care: The Case for Co-operatives

"Home care is not a commodity to be purchased like walking aids, it requires the building of trustbetween the care recipient and giver" (Age Action, 2017, p.14, quoted in Cullen, 2019, p.11).

Driven by the pursuit of cost efficiencies, neoliberal policies have seen the public sector's role change from being a direct provider of care to a commissioner of care. The consequence is the commodification of care, which provides opportunities for (often large, multinational) companies to exploit the needs of vulnerable groups to extract profit, thereby rendering care institutions as "assets owned and flipped for profit within private equity structures" (Cottam, 2020, p.30). While it has been acknowledged that the involvement of the private sector can have a positive impact on standards in the

sector (Mercille and O'Neill, 2022), ultimately the generation of profit is the primary consideration of for-profit business. Most importantly, the commodification of care undermines the relational and interdependent nature of care (Cottam, 2020; Restakis, 2021).

The "cash for care" economy (Cullen 2019, p.7) has led to growing financialisation of the care sector (Hoppania et al., 2024; Horton, 2022), where a small financial elite of investors extracts wealth from the State, from employees, from individuals paying for their own care, and from communities. Referring to the growing financialisation of a huge swathe of aspects of human needs, Kelly (2012, p.2) argues that, to counteract **extractivism**, we need a "generative economy", designed "to create the conditions for life", where workers and communities have an ownership stake in enterprises. Employee ownership models support the "distributive by design" element of doughnut economics (Raworth, 2017b); they help to prevent extractivism and enable the delivery of cost-effective, high-quality care through "economies of co-operation, rather than industrial scale" (Cottam, 2020, p.32).

Because they are owned and governed democratically by those who provide and/or receive a service, co-operatives are an exemplar of the type of enterprise that is needed for a more democratic economy. While co-operatives must be economically viable, they are not driven by the need to maximise return on investment to external shareholders. Any profits generated are re-invested in the business, with provision for some of any surplus generated to be redistributed to members in proportion to their use of the co-operative. In this sense, they are not-for-profit organisations. This facilitates prioritisation of member-owners' interests. In the absence of the need to generate a profit for shareholders, co-operatives may also have lower running costs, although this is not always a given.

2.6.1 The Co-operative Difference

"Relationships are the opposite of transactions. They require a sense of reciprocity, a meeting of equals — a relationship cannot be done to us. Thinking relationally inspires a different institutional design" (Cottam, 2020, p.27).

Enabling a better quality of care requires a more holistic, relationship-centred approach, and is a collective endeavour. As exemplified by many communities during the COVID-19 pandemic, participation in mutual aid networks can optimise opportunities for "individual and collective flourishing" (Cottam, 2020, p.25). The co-operative model provides an appropriate structure and process to support this collective action.

A co-operative is "an autonomous association of persons united voluntarily to meet their common economic, social and cultural needs and aspirations through a jointly-owned and democratically-controlled enterprise" (International Cooperative Alliance, 2018a). Co-operatives may be owned by producers, who want to secure a fair price for their products and get them to market efficiently (e.g. dairy farmers' co-operatives); by consumers who want to access products or services at fair prices and terms (e.g. credit unions); by workers who want to own and work in a democratically controlled enterprise; and by communities or a range of stakeholders who want to provide access to services or develop their communities through a collaborative approach.

Co-operatives are owned and controlled by their members and are underpinned by the values of *self-help, self-responsibility, democracy, equality, equity* and *solidarity*. Thus,

the values of a co-operative align with those of a society which has a partnership orientation, as set out in Partnerism. Adherence to these values is guided by a set of seven co-operative principles Table 2-2.

TABLE 2-2: THE SEVEN CO-OPERATIVE PRINCIPLES.

1. **Voluntary and open membership** Co-operatives are voluntary organisations, which are open to all who can use their services and are willing to accept the responsibilities of membership, without gender, social, racial, political orreligious discrimination.
2. **Democratic member control** Co-operatives are democratic organisations which are controlled by their members, who are actively involved in setting policies and making decisions. Members elect representatives to serve on the board. In primary co-operatives, members (individuals) enjoy equal voting rights (one member, one vote). Co-operatives at other levels (e.g. where a group of co-operatives form asecondary co-operative) are also governed democratically.
3. **Member economic participation** Members contribute equitably to, and democratically control the capital of their co-operative. Surpluses are allocated by the members for several purposes: developing their co-operative, benefiting members in proportion to their transactions with the co-operative, and supporting other activities approved by the membership.
4. **Autonomy and independence** Co-operatives are autonomous, self-help organisations controlled by their members. Any agreements with other bodies must ensure continued democratic control by their members andthe maintenance of the co-operative identity.
5. **Education, training and information** Co-operatives provide education and training for their members, elected representatives, managers, and employees to ensure they can contribute effectively to the development of the co-operative. They inform the general public about the nature and benefits of co-operatives.
6. **Co-operation among co-operatives** Co-operatives serve their members most effectively and strengthen the co-operative movement by working together through local, national, regional and international structures.
7. **Concern for community** Co-operatives work for the sustainable development of their communities through policies approved by their members.

Source: Synopsised from International Co-operative Alliance (2018b).

In a for-profit business, the definition of viability can vary considerably to that of a co-operative. In the former, the company needs to generate a profit sufficient to incentivise investors to continue their investment in the business. Co-operatives, however, exist solely for the purpose of meeting the needs of their members. They must achieve financial viability to reinvest in the co-operative, pay workers fairly and maintain a high-quality service, but they do not have to concern themselves with generating a profit for external shareholders/investors. Thus, the objective of a co-operative aligns with that of an economy in service to society, as envisaged in Doughnut Economics.

2.6.2 Care Co-operatives: The International Experience

The emergence of co-operatives in the care sector (including home care, childcare and other types ofsocial care) is relatively recent. Care co-operatives typically take the form of a worker co-operative, owned and controlled by care workers, or a multi-stakeholder co-operative, which can include workers, care recipients and their advocates, and public and community organisations involved in care provision.

One of the earliest worker co-operatives in the care sector was Cooperative Home Care Associates (CHCA), established in New York in 1985. The premise was that elevating pay and conditions through worker ownership and control would result in higher quality jobs for care workers, which, in turn, would result in a higher quality of service for clients. From an initial group of 12 care workers, the co-operative grew to employ 1,600 staff (CHCA, 2023). In Ireland, the Great Care Co-op (GCC) was set up in 2020 based on the same philosophy of better job quality leading to better care (see Box 2-1).

BOX 2-1: CASE STUDY - THE GREAT CARE CO-OP, IRELAND

The Great Care Co-op (GCC) is a home care co-operative owned and run by care workers. After three years of research and working towards setting up the co-operative, including prototype development and testing with older people and their families, the GCC began trading in 2020. Its first hub was launched to provide home care, initially to private clients and subsequently to HSE- funded clients, in the Dalkey area of South Dublin. Since then, two new hubs are in early-stage development in Bray, Co. Wicklow and in Dublin 4.

The GCC emerged out of the Migrant Rights Centre Ireland (MRCI) in response to the experiences reported by migrant workers involved in domestic work. These workers faced discrimination based on their gender, migrant status and the nature of their domestic work (such as care provision and cleaning) being typically undervalued. In 2014/2015, MRCI partnered with the SIPTU trade union, and Family Carers Ireland to conduct research exploring the challenges faced by workers in the home care sector. A litany of issues were highlighted including: poor pay and conditions (e.g. low pay, insecure contracts, no funding for travelling between clients), no clear job description, insufficient time with clients due to tight schedules, exclusion of care workers from development of personal care plans, poor internal communications, workers fearing loss of work hours if they advocated for their clients, inadequate training, health and safety issues, racism and discrimination based on gender, migrant status and domestic work, and lack of recognition. All of these issues have a negative impact not only on care workers but on the quality of care that they are able to deliver to clients.

Aoife Smith, CEO of the GCC, explained in the CO-AGE webinar (2022):

"We needed to look at some kind of a systemic change model that would look at having great care and great jobs together, that the two were intrinsically linked."

"We needed a paradigm shift. One that would invest in the workers in order to generate good care. And we were basing it on a human rights and equality framework."

The worker co-operative was identified as the organisational model most conducive to investing in and empowering care workers, which in turn creates a better quality of care for clients. The GCC was set up as a company limited by guarantee but applies co-operative principles. As of 2023, the board includes seven carers; four are migrant women and three are Irish women.

All employees can apply to join the GCC once their 6-month probationary period is complete. GCC has not yet implemented a membership fee as it is still in start-up phase but a nominal annual membership fee of €10 is due to be implemented in 2024 for existing and new members. All profits are reinvested in improving workers' pay and conditions, providing access to training and development, and improving care.

The GCC's operational structure is influenced by the principles of the Buurtzorg model (see Buurtzorg, 2023). Originating in the Netherlands in 2006, this community-based, nurse-led model places the client at the centre of care, supported by informal networks of family, friends and neighbours, the professional care team, and the formal network that comprises health professionals such as GPs, public health nurses and other health professionals. With support from the European Social Fund (ESF), the GCC was able to avail of training supports to implement this model.

In contrast to the hierarchical 'time and task' model of care that characterises the dominant model of home care in Ireland, in the GCC (Smith, 2022):

"The care teams work with the friends, families and circles of support of the individual ... to empower and support the individual ... to keep living the way they want, ... to provide that more holistic, socially focused way of caring."

Care workers work in self-managed teams of up to twelve workers in a local community. They do their own scheduling, which gives them more control over hours of work and ensures they can give adequate time to clients, and they make decisions on whether they have the capacity to take on new clients. They are supported, rather than controlled, by a small back-office team, which deals with financial and regulatory aspects of the business and provides coaching for the self-managed teams.

According to Aoife Smith (ibid.), the growth of the home care sector presents "a real opportunity ... to change the narrative of home care ... and to build a sustainable model of care for the future based on sustainable employment. We will not get to where we want to be with the model that we have at the moment. We need systemic change." The GCC offers a model that can be part of this change.

The multi-stakeholder model in social care is generally referred to as a social co-operative. Italy was an early pioneer of social co-operatives, where they emerged in the 1960s and 1970s in response to inadequate care service provision and lack of State

funding (CECOP, 2022). Care co-operatives rapidly expanded in Italy in the 1990s, bolstered by the Social Co-operative Act (1991), which provided a suitable legal framework and designated tax advantages. Employment activation of disadvantaged groups is also a key objective of the Italian movement, supported by the legislation (Conaty, 2014). By 2021, there were approximately 15,000 social co-operatives active in Italy (CECOP, 2021), providing care to over 5 million people (Conaty, 2014; International Labour Organization, 2017). Italian legislation encourages (though does not require) the use of the multi-stakeholder model, for example, including care receivers, care providers and volunteers as members. This extends to co-design and co-development of services with input from a range of stakeholders, and collaboration with local authorities. The development of new social co-operatives in Italy is also supported by what is known as the 'strawberry patch' principle (Conaty, 2014), where each successful co-operative is expected to mentor a new co-operative. This is in the spirit of the co-operative principle of 'co-operation among co-operatives'.

Following Italy's example, Canada, and especially the province of Quebec, was another early pioneer of the multi-stakeholder social co-operative model in the mid-1990s (Conaty, 2014). Since then, care co-operatives have grown in several other countries, including the US, Japan, France, Spain, Poland, Finland, Sweden, and the UK.

The multi-stakeholder co-operative model's emphasis on collaboration and engagement with care recipients, their family members, public bodies in the care sector, and civil society groups, offers potential to enhance the effectiveness of the service provided and its accessibility. Collaboration with public authorities in the care sector recognises "their important contribution to balancing quality with affordability and positive impact on the community" (CECOP, 2022, p.13). Restakis (2021, p.186) argues that "[s]ocial cooperatives are the most promising attempt to re-humanise social care by restoring the social and interpersonal relations that are its foundation". Equal Care Co-op provides an example of a multi-stakeholder co-operative set up in the UK in 2019 (see Box 2-2).

BOX 2-2: CASE STUDY - EQUAL CARE CO-OP, UK

Equal Care Co-op is a registered multi-stakeholder co-operative society, founded in the UK in 2019. It was set up in response to the "conveyor belt care" system, which marginalises the interests of those at the centre of the caregiving relationship – those receiving care and those providing care (Back, 2022).

The co-operative began providing care services in Calderdale, West Yorkshire in 2020 and, more recently, has expanded to two London boroughs, with plans to provide services in further local authority areas over time. Most of Equal Care Co-op's work is with clients who are self-funded or have an allocated personal budget which allows them to choose their care provider. More recently, they have also been contracted to provide care on behalf of a local authority.

Equal Care Co-op uses a digital platform to create care teams customised for individual clients. Teams are led by the person receiving care or a trusted advocate. Unlike conventional systems where a care worker is assigned to an individual, clients are facilitated to select a care worker registered on the Equal Care platform. The client and care workers enter into a care relationship by mutual agreement. Clients can also nominate family, friends and neighbours, and health and social care professionals to

their care team. All co-ordination is done through the digital platform. Equal Care Co-op provides the services of a 'team starter' to guide the client in setting up the team and identifying thesupports they need to enable them to live well at home.

According to founder, Emma Back (2022):

"The mutual consent and the mutual choice that those relationships start out with tend to result inmuch more sustainable, much more committed, much more loyal, much more honest care-giving relationships and that's often where that respect really springs from in a very sincere and real way."

Care workers can choose whether to be an Equal Care employee or to work independently. All careworkers go through the same vetting and selection processes. Each worker sets up a profile on the platform. Independent workers set their own rates and, generally, earn £15-£20 per hour, while employed workers are paid a salary at the Real Living Wage rate of £21,255 per year for a full-timerole.

Equal Care Co-op operates a highly decentralised, peer governance structure, known as sociocracy(ibid.).

"The core governance model of Equal Care is the team. That is where those care and supportdecisions are made ... in the main, the person who's receiving that support is making those decisions, and team members will take on individual roles within the team, wearing different hatsand again supported by the platform."

"The next layer up is the circles, ... Each circle is responsible for the teams in its area. Circles again make decisions by consent, and we use a governance model called 'sociocracy' to do that,where the usual role of the manager is split out into four roles [facilitator, secretary, leader anddelegate] that are again nominated by consent."

This contrasts with the hierarchical structures of conventional systems and saves costs by strippingout middle management layers, enabling the co-operative to pay better rates to workers.

While acknowledging the UK's progress in transitioning from an institution-centred to a person-centred care model, Equal Care Co-op seeks to shift the focus to the relationship between carer and receiver.

According to Emma Back (ibid.):

"Person-centred is very customer centric, it's all about individual needs, 'the customer's always right' ... but it doesn't look at really the relationship that exists between the person receiving and the person giving ... and it always assumes that there is the 'service user' as opposed to this much more reciprocal, mutual aid relationship that involves compromise, it involves consent, and it involves 'give and take'. And each relationship is unique. You cannot just substitute one care worker foranother. It doesn't work."

Members of the co-operative include those receiving care or their advocates, those providing care on a paid or voluntary basis, and donors and investors who believe in the mission of the co-operativeand want to support it. Membership of the board includes up to five supported/advocate members, up to five worker members, and up to two investors members.

Equal Care Co-op has participated in a Community Share Offer, a scheme that allows co-operatives and community organisations to raise capital by offering withdrawable and non-transferable shares to investors who, in turn, receive tax relief on their investment. Under the share offering that closed in 2023, supporters were able to invest between £100 and £100,000 in the co-operative, and avail of 30% tax relief.

Through its engagement with stakeholders, including individuals with lived experience of giving and providing care, local authorities, home care providers, and educational institutions, Equal Care Co-op devotes significant time and energy to consciousness-raising and stimulating debate, with the aspiration to redress power imbalances in the care system.

2.6.3 Partnerism and Co-design in Co-operatives

From the care recipient's perspective, co-operatives can offer a high quality of care because they are 'human-centred', rather than profit-centred, and are driven by a "genuine desire to serve their communities" (CECOP, 2022, p.6). The past half-century has seen businesses increasingly engaging the users of their products and services in processes of participatory design or co-design. However, this has taken a while as it challenges existing hierarchical power structures, requiring industry experts to relinquish a degree of control in the design process in favour of consumers or users of products and services (Sanders and Stappers, 2008). Conversely, the concept and practice of 'design for use' is intrinsic to co-operatives. The theory of co-operative action proposes that human needs are met most effectively when people work together to devise organisational structures, strategies and services that will enable them to meet their shared needs (Briscoe and Ward, 2005). According to co-operative values and principles, people are "treated as origins of action, not passive subjects to be serviced and manipulated" (ibid., p.37). Those needing the service are regarded as having some expertise in terms of what they need, and how this can be delivered.

Whether owned by workers or multiple stakeholders, co-operatives can facilitate more meaningful participation the in co-production of services than public or for-profit organisations (Pestoff, 2009). The multi-stakeholder social co-operative model offers particular advantages for serving collective interests, through formal participation in governance, but also through the more informal interaction between different types of stakeholders (Defourny and Nyseens, 2013, p.28).

With some exceptions, most care co-operatives tend to be small to medium in size (e.g. the average number of member-workers per co-operative in Italy is 30, and 55 in Spain) and operate within a local area (CECOP, 2022). Small size can contribute to more personalised care (Restakis, 2008). Furthermore, because they tend to operate within a limited local area, and as they are locally and collectively owned, they are likely to be more deeply embedded in the community that they serve (CECOP, 2022). Such spatial and relational proximity to members is seen as a source of member value and competitive advantage for co-operatives, whereby those providing a service through the co-operative can more easily understand the 'life world' and needs of their members (Byrne et al., 2015). These characteristics suggest that the smaller scale and localness of co-operatives are conducive to partnerism.

Where scale is required, for example, to compete for public service tenders, this can often be achieved by forming consortia or secondary co-operatives, where the local co-operative maintains its autonomy but can co-operate with other co-operatives to serve their mutual interests and local needs. Such entities can also support co-operative development, providing incubation, consultancyand training support (Doyle, 2022).

2.6.4 Prospects for Better Working Conditions and Job Satisfaction

Comparatively poor pay and conditions of workers in for-profit care companies vis-a-vis their counterparts in the public sector have been highlighted (O'Neill et al., 2023). However, this does not mean that the absence of a profit motive leads to greater job satisfaction. While working conditions in non-profit organisations tend to be better than in the for-profit sector, they are still inferior to those in the public sector (ibid., 2023). Recent studies by Harvey (2021) and O'Neill et al. (2023) highlight this lack of parity, which is evident across a range of factors, including limited or no pension provision, absence of a progressive paystructure, precarious employment contracts, low morale, stress and burnout, and high turnover of staff.

Therefore, working in a socially motivated rather than profit-motivated elder care setting does not guarantee better pay and conditions for employees. The capacity of state-funded organisations in the community and voluntary sector to offer better pay and conditions to staff is significantly restricted by underfunding. Co-operatives that are contracted to provide care on behalf of the State are, of course, also vulnerable to these limitations. However, the co-operative model has been identified as offering a solution to many exploitative practices in care work by recognising, reducing and redistributing unpaid care work, and by rewarding and representing care workers (CECOP, 2022, p.6). They address issues of workplace precarity, enabling care workers to transition from the grey economy by offering legal employment on a more stable footing, and access to labour rights. Furthermore, research from Italy has shown lower rates of staff turnover in co-operatives compared to the wider care sector, while the majority of care workers in co-operatives in Italy and Portugal enjoyed permanent or open-ended contracts (CECOP, 2022).

The desire for improved work-life balance is often a key motivation for workers to form or join a co-operative. The involvement of workers in the democratic control of the enterprise can provide more flexibility and autonomy to workers. Survey research of French co-operatives by CGSCOP (2020), and case study research by Eurofound (2019) on employees' experience in the wider co-operative and social enterprise sectors, highlights employees' higher levels of job quality and quality of life compared with those in conventional businesses (cited in CECOP, 2022). Moreover, higher levels of job satisfaction in worker co-operatives arising from co-ownership and greater control over the work environment can translate into higher standards of care (Berry and Bell, 2018; Doyle, 2022).

In their study of social enterprises engaged in long-term elder care, Cassini et al. (2018) found that greater job satisfaction and employee well-being derive from workplace innovations such as flexible organisation, participative management, autonomy, and opportunities for personaldevelopment. T he co-operative model, through its emphases on democratic governance and service to members, lends itself to such innovations, all of which are more likely to result in services with an orientation towards the social configuration of partnership.

3 Methods

3.1 Research Design

This study was designed to engage stakeholders in discussion on the potential of the co-operative model to provide a solution to future home care needs in Ireland. Focus groups were chosen as the most appropriate forum, as participants were able to explore issues together, facilitated by the researchers.

3.1.1 Knowledge Exchange Webinar

In Ireland, the application of the co-operative model beyond credit unions and agriculture is not well understood. Therefore, it was important to present information to stakeholders in an accessible way to enable them to reflect and make informed contributions to focus group discussions. To this end, a knowledge exchange webinar, open to members of the public and featuring invited speakers from care co-operatives in Ireland and the UK, was held on 23 June 2022. The invited speakers were Aoife Smith, co-founder and CEO of the Great Care Co-op, Dublin; Veronica Barrett, Director of Services, Roscommon Home Care Services[9]; and Emma Back, co-founder of Equal Care Co-op, Yorkshire. The researchers also spoke at this webinar. Presentations were followed by a discussion with other invited panellists.[10] The webinar was recorded and, with the permission of speakers and panellists, was made available on the CO-AGE project webpage for viewing by intending focus group participants and other interested stakeholders.[11] The researchers developed summary sheets to capture key points made by the webinar speakers. These summary sheets, which were available on the project webpage, provided a quick reference guide that participants could read before the focus groups.

To facilitate participants who did not watch the recordings in advance, at the start of each focus group the researchers delivered a short presentation, which provided an overview of the care co-operative model and included highlights from the webinar speakers.

3.1.2 Ethical Approval

Prior to recruiting participants for the study, the research design and instruments were submitted to University College Cork's Social Research Ethics Committee. Ethical approval was granted by this committee (Log 2022-136).

3.1.3 Study Promotion and Participant Recruitment

Those who attended the webinar were invited to register their interest in participating in one of the focus groups. The researchers considered the advantages and disadvantages of holding focus groups online or in person. During the pandemic

[9] Veronica Barrett was unable to present on the day of the webinar. She agreed to an interview andgave permission for this to be posted to the project webpage. https://ucc.cloud.panopto.eu/Panopto/Pages/Viewer.aspx?id=466bdef3-35e2-4e0a-a879-af0700b963d4

[10] Mary Murphy, Age Action Ireland; Darragh Walshe, ICOS; and Michael Harty, Homecare Direct.

[11] https://www.ucc.ie/en/iss21/researchprojects/researchprojects/earlieriss21projects/co-age/

restrictions, many people became more comfortable with using digital platforms and online focus groups became more common in research. The online medium offered significant advantages. Firstly, while Irish society was emerging from pandemic restrictions at the time that the research was designed (2022), the researchers were mindful that some people may be reluctant to travel and to meet others in person. Secondly, online meetings reduced physical distance as a barrier to participation. The locational distribution of certain professional stakeholders, and a desire to ensure the participation of a geographically widespread sample of older people, family carers and care workers, were significant considerations. It is acknowledged that the online medium does risk excluding some older people who may not be comfortable with digital platforms, particularly in the context of Age Action's prioritisation of digital inclusion for older people. However, given that the definition of the 'older people' target group was those aged 55+ who were planning for their future care needs, it was believed that online focus groups would not be a significant impediment to participation. Nevertheless, it was agreed that alternative arrangements would be made to include anyone who wished to participate and could not join an online meeting. No such individuals presented, and all focus groups were conducted online.

The researchers took the following multi-pronged approach to recruiting additional participants for the focus groups.

3.1.3.1 Older people and caregivers

Several organisations and initiatives that engage with older populations and/or caregivers shared information and recruitment posters for the research study with the target groups, namely older people interested in future planning, family carers and care workers. They disseminated the information through a range of channels, including social media, newsletters, special interest networks and citizen research databases. Intermediaries also made direct appeals to their contacts to help recruit some of the care workers who took part in the study. The researchers are grateful to the following for their support with promotion and/or recruitment: Age Action, Age and Opportunity, Age Friendly Ireland (including Older People's Councils), Alzheimers Society of Ireland and TeamUp for Dementia, Family Carers Ireland, SIPTU and the Great Care Co-op. The researchers received 21 Expressions of Interest from people in Ireland who were (1) interested in care planning for the future, (2) family carers or other relatives, and (3) people with experience of working in the care system. Nineteen proceeded to complete a consent form to participate in the research and 17 took part in one of the three focus groups held in November 2022.

3.1.3.2 Relevant professionals

The researchers made direct contact by email and/or phone with 16 professionals whom they identified as having expertise relevant to the development of care co-operatives in Ireland to invite them to participate in a focus group. These included people directly involved in co-operative development, along with others working in community finance, community development, and advocacy initiatives or care services for older people. Fifteen agreed and, of these, ten went on to provide consent and participate in one of the two focus groups held in December 2022.

3.1.4 Research Participants

Overall, the research heard from 30 respondents during the course of the research, comprising two webinar presenters and one online interviewee involved in co-operatives delivering care services (all female) and 27 focus group participants (20 females and seven males). Focus group participants came from Connacht, Munster and Leinster, and a range of area types ranging from countryside or village to town, city or suburb. Care workers who took part in the focus groups had experience in a range of institutional settings (home care and residential care), of specialisms (general care, continuing care, rehabilitation and psychiatric) and of organisational models (HSE, for-profit and non-profit/social economy).

3.2 Focus Group Data Collection and Processing

Five focus groups were conducted with research participants and recorded using MS Teams. The researchers used a focus group discussion guide that was tailored to each group of stakeholders. The discussions were semi-structured, ensuring that key research questions were addressed while giving the flexibility to explore issues raised by participants.

The qualitative data in the transcripts from each focus group recording were processed using NVivo software to support thematic analysis (Section 3.4.2).

3.3 Engagement with the HSE

In March 2022, during the planning phase of the study, the researchers established contact with the HSE office responsible for Services for Older People, Change and Innovation. A member of HSE staff was nominated to represent that office and participated in a meeting with one of the researchers in June 2022 to discuss how the HSE might be able to support the study. There was a useful discussion of some current developments in the care sector for the researchers to bear in mind. Subsequently, the main form of engagement was through a written submission of questions. This was sent to the HSE in August 2022 and a response was received in June 2023.[12]

[12] The HSE nominee was invited to an online meeting of the project advisory panel in April 2022. As the nominee was unable to attend, a separate one-to-one online meeting was held in June 2022 to outline the project and to explore how the HSE might support it. At that meeting, the HSE representative advised that the HSE would respond to a written submission of questions seeking information and clarifications on policies and processes. The representative also indicated that it might be possible to arrange interviews or focus groups with relevant staff. A list of questions was submitted to the nominated HSE officer in August 2022. One of the researchers followed up several times on the request for a response to the submitted questions. When no response was forthcoming, it seemed to be related to staffing changes and redeployments. Once the HSE established which members of staff could support the study, the questions were resubmitted in May 2023. The HSE scheduled meetings with one of the researchers, involving various relevant HSE staff, for May and June 2023, all of which were rescheduled at the request of the HSE due to diary conflicts of staff who were due to attend. In the interests of progressing the project, the researcher suggested that a written response would suffice. A written response was received in June 2023.

The HSE points of contacts were also invited to the CO-AGE webinar in June 2022, either as panellists or observers, but were unable to attend.

3.4 Data Analysis

3.4.1 Epistemological Approach

CO-AGE was a short-term exploratory research study that was conducted by researchers experienced in using qualitative methods in social research and who both had personal experience of caring for older people in Ireland. Consequently, the researchers adopted a "subtle realist approach" (Brooks et al., 2015, p.205) that acknowledges the inevitable influence of the researchers' positions in the social world on their perspectives while, at the same time, considers that the subject matter under investigation is still sufficiently independent of them to be discoverable through the study.

Additionally, a validation process was incorporated into the methodology. This is whereby all research participants were invited to an online feedback session during which the researchers presented their draft findings from the thematic analysis and opened up their interpretation to participants' critique and feedback (Section 3.4.2.2).

3.4.2 Thematic Analysis

The researchers selected a moderately qualitative form of thematic analysis known as the codebook approach for the following reasons.

Firstly, the CO-AGE researchers are experienced in (a) qualitative research into social issues using interviews and/or focus groups and (b) the use of thematic analysis or TA. They also have prior and ongoing personal experience of the research subject i.e. caring for older relatives as family carer and/or as other supportive relatives. In light of those personal encounters with elder care, both have reflected on the need for advance care planning. Furthermore, one researcher is an academic expert on co-operatives. Thus, the codebook approach offered the researchers the flexibility and scope for ongoing revision and iteration as their understandings deepened throughout the thematic analysis.

Secondly, as a piece of applied research of societal interest, the outputs needed to be accessible to a lay audience, along with policy makers and the research community. The structured and multi-level codebook approach to thematic analysis offered the researchers a readily understandable form of outputs.

3.4.2.1 Codes, themes and topics

The researchers followed guidance on qualitative and thematic analysis from Yin (2016) and Braun and Clarke (2006; 2012). A code can be understood as a single observation or idea, or taking what people say at face value. Several codes may relate to each other in ways that reveal a theme to the researcher. A theme is likely to either require interpretation by the researcher or be the outcome of interpretation by a research participant. In this study, the researchers elucidated themes as they proceeded to understand and query relationships between codes. Having first read over the transcripts to become familiar with the data, the researchers generated initial codes, before proceeding to search for relationships among them and then to identify, review and refine themes. This was done through an iterative and reflexive process combining independent working with periodic meetings to share observations and co-ordinate the emerging codebook and subsequent analysis.

Researcher 1 focused on developing codes and identifying themes from testimonies relating to participants' experiences and perceptions of 'care' more generally, while Researcher 2 (who has specialist expertise in the co-operative sector) concentrated on discussions relating to the organisation of care through the 'co-operative' and other models. These were then brought together into one coherent coding template, which the researchers used to code all of the transcripts and uncover themes.

The final revision of themes is presented as mind maps in Chapters 4 and 5. In those chapters, codes are referred to as 'topics'.

3.4.2.2 Validating the thematic analysis

The researchers ran two online feedback sessions on MS Teams in June 2023 with interested and available participants from the study's earlier focus groups. Comprising presentations by the researchers followed by an open discussion with attendees, these served two objectives: (1) the informed audience gave the researchers a strong sounding board to help to validate the research findings and address the risk of the researchers subjectifying the interpretation and (2) it offered the research participants a further opportunity to inform and help to shape the emerging research report. Participants did indeed welcome the opportunity to ask follow-up questions, share further feedback and continue to discuss ageing and care in Ireland generally.

Participants in these feedback sessions included the community partner Age Action and nine others representing remits and/or interests in age advocacy, co-operative development, community development, community finance, care workers and older people planning for their future.

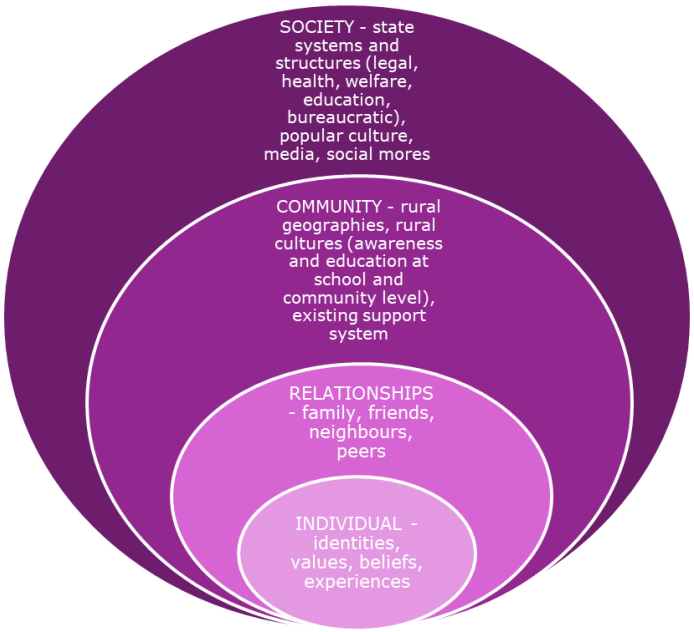
3.4.3 The Social-Ecological Model

The social-ecological model is an analytical framework that was used to help structure research findings and their presentation. The framework moves the focus from the individual alone to also encompass their family, friends, community, and society; in other words, the wider social-ecological system in which people live (Pardeck, 1988). The framework is 'ecological' or holobiont as each level is nested within the next, which reflects that components within and across tiers are interrelated and interdependent. These are the relationship dynamics that Eisler highlights in Partnerism, and what Labrum and Solomon (2015, p.295) calls the "tiered interacting domains influencing human behaviour".

The social-ecological model or SEM has been used in diverse areas of social care research and meta-analyses, including by the World Health Organisation (e.g. Krug et al., 2002) to tease out and demonstrate findings at various scales of human relations. Differentiating findings in this way can help to elucidate interventions appropriate to each level. Areas of research that have used the SEM include health outcomes for vulnerable adults (of refugee women - Hawkins et al., 2021, of low-income workers - Baron et al., 2014), the impacts of abusive human behaviour such as gender-based violence against women (Heise, 1998; Terry, 2014), political violence against children (Cummings et al., 2014), and factors that impact on the use of advanced medical technologies in home care (e.g. National Research Council, 2010). By way of example, Figure 3-1 fleshes out the diverse factors at each level as they relate to the appropriate design of sexual violence supports in a rural region in Ireland.

The SEM "understands health to be affected by the interaction between the individual, the group/community, and the physical, social and political environments" (Clinical and Translational Science Awards Consortium et al., 2011, p.20). It sees health, and by extension human wellbeing and social care, as a complex system that calls for a systems-based approach to interventions too. In other words, successful care interventions will be those developed and integrated across the various levels of the system. For example, in his review of three national elder health and social care programmes in the US and Canada, Kodner (2006) found that integrated strategies were helping to address not only such shortcomings as fragmented services, disjointed care, poor quality, inefficiencies and rising costs, but were also resulting in better outcomes for care recipients and carers. Similarly, the field of public health is challenging the limits of the traditional biomedical paradigm through its use of the social-ecological model (Golden and Wendel, 2020).

FIGURE 3-1: INTER-RELATEDNESS AND INTER-DEPENDENCE IN THE SOCIAL-ECOLOGICAL MODEL.



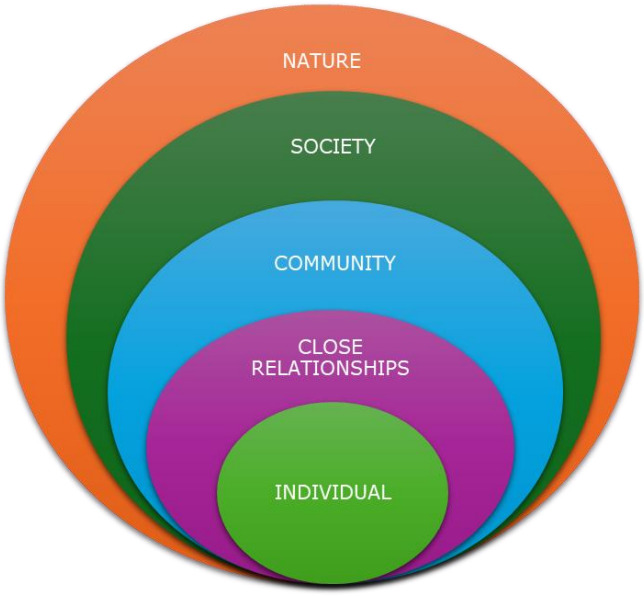
Source: Crowley, Mulholland and Ryan (2021, p.16).

In the case of CO-AGE, the social-ecological framework allowed the researchers to organise the data gathered across varying levels of care recipient / family carer and household / care worker experience along with factors that lie at community level and more broadly at societal level in Chapter 4. In turn, the framework was used in the presentation of conclusions in Chapter 6 that respond to the findings at each level of the social-ecological model.

4 The Care System Experience

Using the social-ecological framework, Chapter 4 sets out the data and findings from the research in the four nested levels of the individual, close relationships, community and society[13] (Figure 4-1). It focuses on the lived experience of research participants who have encountered the care system as care receivers or caregivers (paid and unpaid); and the preferences of those who have reflected on how they would like their future care needs, or those of loved ones and others, to be met. This provides the wider context within which the model of care co-operatives will then be explored in Chapter 5.

FIGURE 4-1: SOCIAL-ECOLOGICAL FRAMEWORK.



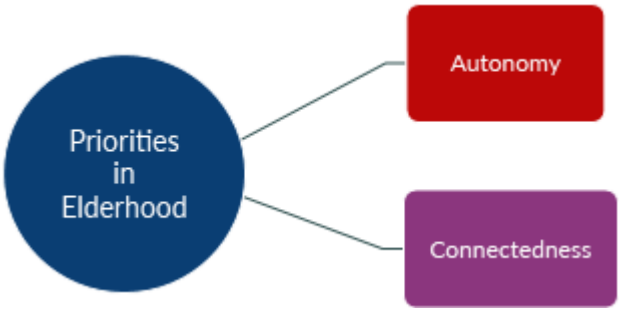
4.1 Individual Level – Priorities in Elderhood

While this section is notionally about older people as 'individuals', there are inescapable overlaps with the levels of 'close relationships' and 'community' in particular. These will be built upon more explicitly when those levels are explored in the following sections.

Geriatrician Louise Aronson (2019) coined the term 'elderhood' to challenge the bias towards old age in Western society, including by changing the language used when discussing it. When asked about their priorities for themselves or their loved ones as they grow older in Ireland, focus group participants gave a range of answers, which were coded by the researchers into two themes: (1) autonomy or freedom of choice and (2) connectedness e.g. to family, home and community (Figure 4-2).

[13] While 'nature' is not a focus of this research study, it is included here in recognition of the view that human beings are part of nature.

FIGURE 4-2: THEMES AT THE INDIVIDUAL LEVEL.



These two themes go to the heart of essential human needs, and the tension that can exist between them is a core subject in the work of clinician and trauma specialist Dr Gabor Maté, who advocates for a holistic body-mind approach in medicine. He argues that 'authenticity' and 'attachment' are human drives that are "rooted in survival instincts" (Maté and Maté, 2022, p.106).

Authenticity is "the quality of being true to oneself, and the capacity to shape one's own life from a deep knowledge of that self" (ibid., p.106). Thus, having freedom of choice or autonomy is vital for one's authenticity. Attachment "is the drive for closeness – proximity to others, in not only the physical but the emotional sense as well ... to facilitate either caretaking or being taken care of" and "is indispensable for life" (ibid., p.105). Thus, remaining connected with significant others is also essential for one's physical and mental wellbeing.

It is important for people to be able to meet their needs for authenticity and for attachment throughout their lives and, ideally, each would be facilitative of the other. For instance, people's ability to exercise their preferences, including to live independently in older age, often relies on the support of others. Yet, even though all humans are dependent on others to varying degrees throughout their lives to meet their needs, Western culture tends to associate dignity with independence and autonomy, giving rise to a cultural prejudice against dependence (Tolo Heggestad et al., 2015). Instead of an emphasis on either independence or dependence, it may be more accurate to think in terms of 'interdependence', where one's autonomy depends on social relationships or relational autonomy (ibid.). Relational autonomy can be understood as autonomy that is enabled by care, where the care is experienced as enabling because it respects autonomy (Davy, 2019).

4.1.1 Autonomy

Starting with the human need for authenticity, CO-AGE focus group participants highlighted the importance of older people maintaining their autonomy and freedom of choice. As the following olderpersons' advocate said:

"It's retaining your ability to make choices about your life. If you want to stay in your house, you canstay in your house. If you want to stay up till 1:00 AM, you can stay up till 1:00 AM. If you want to have people over, if you want to 'whatever', you still can make those decisions in your life."

A retired health professional described how, by contrast, patients in older age in the hospital where she once worked had lacked choice in terms of when they slept or what they ate.

Looking ahead to their own future as an ageing rural dweller, the following participant pondered the challenge of adapting to increasing dependence on others if they could no longer drive themselves. It indicates how relational autonomy requires negotiation, including with oneself.

"... in a way, it's in your own self. It's being dependent on others when you've spent your life being independent ... I think I would find that very difficult. ... I'd have to sort of rethink myself if I was everfaced with that."

4.1.2 Connectedness

Turning next to the human need for 'attachment', participants talked about the importance of connectedness to their family, including to younger people (because "variety" is important). They also spoke of connectednessto their familiar homeplace and/or their community. Living at home, it was argued, would be more cost effective "in every sense" and even lead to a longer life. As one family carer said of their father:

"... I know by living in his own home, it extended his life certainly by four if not five years."

In the first quote below, a person planning for their older years hoped for a scenario where they could downsize into a small dwelling while their adult children and grandchildren moved into the current large family home nearby. It was important for the older person not just to live close to their family; they particularly wished to be among their younger relatives:

"I can't imagine living in a community where there's only old people because if you need something done, ask your grandchild. They can sort out Zoom, Teams, all those other things. Imagine sitting in aroom with the television on from 11 o'clock and all you see are [older people]. I mean, it's hell!"

A family carer agreed, highlighting how being surrounded by many young people kept her father "very much alive". Another family carer concurred that far from feeling a sense of attachment with those around them in a nursing home, they feared they would be:

"... surrounded by people who are maybe not a comfort to me, but a sense of dread."

Turning to the interconnection of home and locality, two family carers explained in the following quotes how one's home was embedded in the community:

"He'd lived in the same house since 1961, was very much part of the community .... I realised then that it was very important that he stay in his own home. ... he had his confidence up to the very end. He felt that he was needed, that he wasn't just kind of shoved away. And I really would like that myself, to continue on to be a member of the community, to be needed, to be wanted, to feel that I have still something to give, even though I'm old ..."

"… we kept him mobile much longer. We kept him interested and stimulated, and he has a sense ofwell-being that he calls home. But it's more that he has people coming in and out. He knows them, it's stable, he is cared for as a person."

Being supported to age at home, and thus in one's community, indicated to the older person that they were still 'relevant', 'needed' and 'cared for' by others, and it made it easy for people to visit them, all of which helped older people to feel safe, support their self-esteem, stimulate them and even maintain their mobility as they aged.

A forward planner who is active and networked within their community explained that the practical support of friends and neighbours would be accessible to them if they lived at home:

"I want to stay in my own home ... because this is my community and I want to stay in my community. I don't want to be uprooted from my community. My community is very important to me and all the friends and all the support and all the people I know around me. And when COVID struck, that really came home, the kindness of my neighbours."

The family home and garden can represent a deep thread of family social history attaching the individual to previous generations too:

"... my grandmother built this house that I'm living in, so that has huge significance for me and the memories and what she went through to do it and how she gardened ... So, it's not just moving some place and losing all my friends and all the people I know ... it's losing my history, it's losing my past ..."

Surveys in Ireland confirm that the majority of people wish to continue living in their home in older age. In 2021, 78% of rural dwellers expressed a preference to do so, reiterating the findings of a 2015 survey which found that 78% of older people would also prefer to adapt their own home (O'Sullivan et al., 2022). A theme running through this report is the importance of the care system being adaptable so that it can cater for the diversity of human needs and preferences as people age. Later in the report, this will be explored in terms of a 'continuum of care'.

'Home' can mean different things to different people based on their lived experience and even their medical conditions that present in later years, as this relative discovered:

"... her Alzheimer's, it progressed so fast that she became afraid in her own home ... She didn't recognise it, pretty much overnight, as her own home. .... And later on, when she would talk abouthome, it was her home when she was a child. .... [home is] as much a way a person feels as opposed to necessarily the place."

What the last insight suggests is that the physical house is not always what matters. Rather, it is how people feel *in relation to* their residence. For some, the house can represent connection with family and, by extension, the wider community in which the family is embedded. That connection may be bound up with layers of meaning in terms of the regard in which one is held within the community and of belonging. Some participants cautioned that for others, a house might become a barrier to them maintaining the connectedness they desire. For instance, one participant recalled a neighbour who had to relocate to a nursing home despite being capable of continuing to live in the community with a little help from a home support service:

"because the home wasn't suitable for her care needs anymore ... her own home became the barrier to her living independently."

Thus, it seems to be important when planning for one's older years to remain open to alternative housing options in the community. Of course, this will be contingent on the availability of alternative options.

The desirability of 'ageing in place', which has been well-established in national and international research, holds true in this study too. People wish to remain living in their community, rather than in a nursing home, and with some degree of independence (Amárach Research, 2016; Cullen et al., 2007; O'Sullivan et al., 2022; Wiles et al., 2011). That would satisfy the higher essential human needs of attachment and authenticity, which continue into elderhood. Indeed, both factors should be key considerations in a more holistic and integrated approach to how care is designed and delivered throughout the life cycle, rather than the current medical model of home care that tends to focus narrowly on physiological needs in particular.

4.2 Close Relationships Level - Household Role in Care

This section looks more explicitly at the role of 'close relationships' when it comes to the care of older people, both in terms of their own actions and the actions of others. From the transcripts of the focus groups, the researchers identified a number of themes in terms of the 'household or family role in care' (Figure 4-3).

Participants discussed the influence of close relationships when planning for their own care in the future or in past experiences of supporting older relatives. Older people described taking personal responsibility for their own care planning *in light of their close relationships with others*, e.g. out of consideration for their children. Family members described taking responsibility for loved ones because they could no longer manage by themselves. In either case, care planning involved making adjustments to one's home or living arrangements.

4.2.1 Personal Responsibility

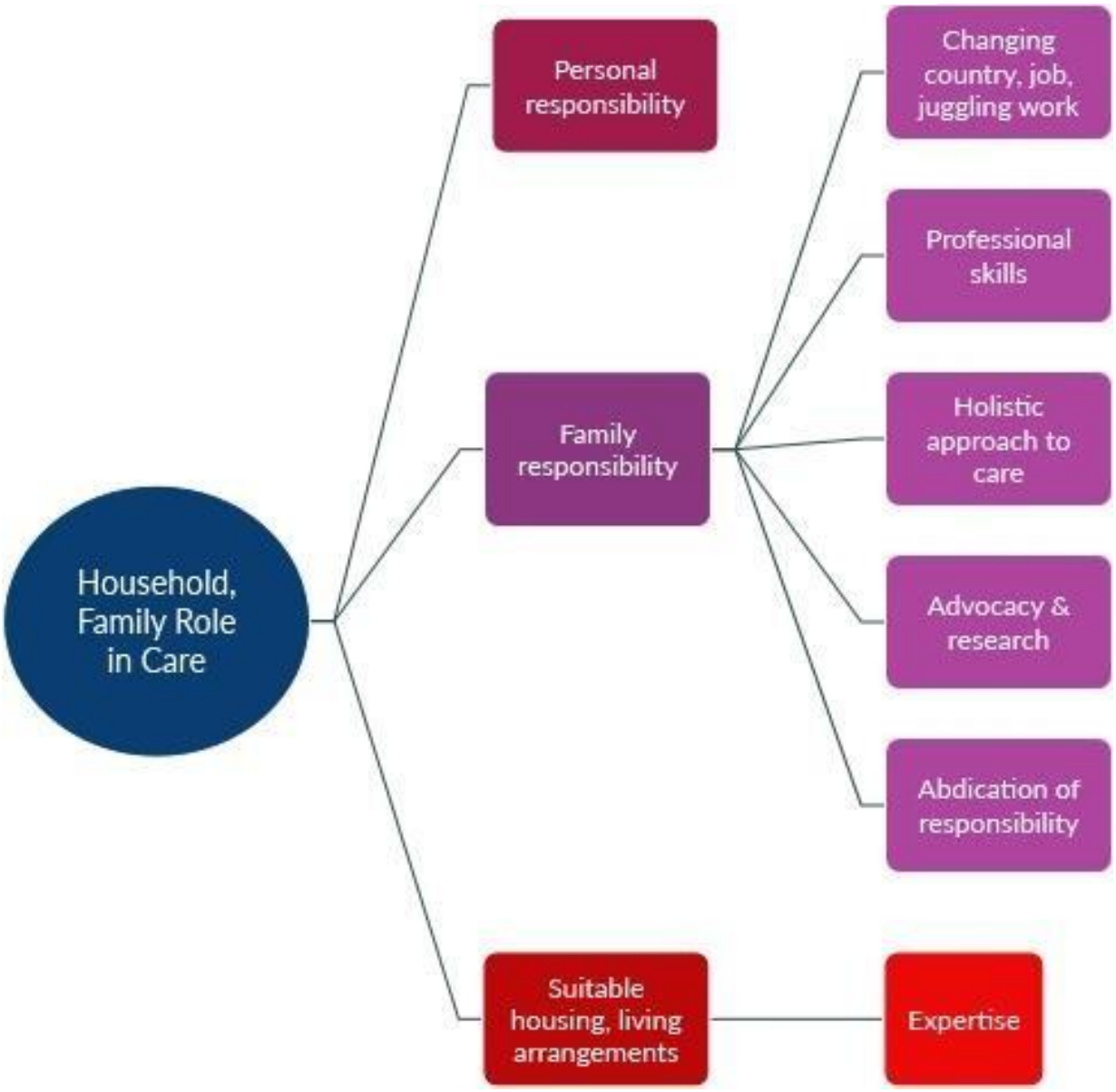
Planning for an unknown future worried some participants, especially as the population ages, the pension age is extended and there is general unease regarding the State's capacity to manage growing demand for services in the current care system. Those thinking of the future wondered when they should start planning and how they might manage the financial implications. Not understanding how the care system worked was another issue they encountered:

"and, it is a big weight on ... your shoulders, 'how is this going to work out?', because you don't know if you're going to need it ..."

"Do I build in a little fall-back plan as to move into a smaller house, one that hasn't got stairs? Do you start planning from your late 60s doing that, the minute you can start getting the pension, [or do] you put aside some money in your 50s?"

"... it's when you start to need the care that you first meet it and then it's too late and you just have to get on with it and you don't know, really, how it works. We had that experience with my mother ... we couldn't help her at home, she had so many needs ... So that's where we met the system really very, very quickly ..."

FIGURE 4-3: THEMES AND TOPICS OF THE 'HOUSEHOLD / CLOSE RELATIONSHIPS' LEVEL.



The nature of one's close relationships can be a driving force for taking personal responsibility for care planning. For instance, the following former family carer was keenly aware of their need to plan for their own future because they were a single person:

"... I'm looking down the road and saying, 'well, I'm not married, so what is going to happen to me?' I can't rely on people to look after me."

Another former family carer was taking care planning into their own hands because their relationships with siblings were not close, and they felt that they had "nobody".

The following participants were applying the experience they had gained in the past while helping their parents to now plan for their own anticipated future care needs. A key motivation was to relieve their children ofthat responsibility.

"Having been through this experience with both mothers [mother and mother-in-law], it obviously impacts on how I look at my future. So, I've had conversations with [my adult]

son ... and a daughter .... and obviously my husband too, to see if we can look at the continuum of care [for my progressive illness] and the phased approach."

"I downsized. .... I'm doing everything I can to try and relieve the pressure that it might cause on myfamily members."

This is especially important considering that close relatives could be busy with their own work andcaregiving responsibilities as the following forward planner outlined:

"our children are much younger and will be in the middle of their careers and maybe with youngfamilies, so they won't be available to do the leg work and all of that for us."

Personal responsibility calls for personal capacity, but that varies widely across the population. Oftentimes, people will need the support of others to help with planning and managing their care in older years and this is likely to be a family member in the first instance.

4.2.2 Family Responsibility

Several topics were discussed under the theme of family members taking responsibility for their loved one's care in older age. The researchers learned about some of the implications for family carers who did take responsibility, the care approach taken, and the professional skills that they brought to their caring role, including advocacy work and research participation even after the caring role ended. There were also examples where families abdicated responsibility for a relative's care in older age.

Family carers talked about helping a relative to modify their house or combining caregiving withtheir job. The researchers also heard from family carers who had left a job to care for a relative, including some who returned home from overseas. The first two quotes are from family carers who were themselves care workers:

"I kinda have it from both angles where I had care in my own home [for my spouse and child] to assist me to get to work [as a care worker] to pay the bills."

"I worked in a nursing home ... and during that time my father got very ill, so ... That was my decisionto stay at home to look after him till he passed."

"I took six months off and came back [from overseas] so that [my father] could stay in his own home."

Personal implications for family carers included adapting their own house to accommodate an elder relative, along with drawing on their professional skills as a nurse or a care worker:

"I was a carer for my mother for a long time. ... and my whole house was like a hospital because I had a hoist and a hospital bed and all that. But I managed ... because I was a nurse, and I was used to it .... but 'tis a completely different situation in a hospital. You can walk away from it after 8 hours or 12 hours ... whereas you're stuck with it here ..."

The following family carer took a holistic approach to caring for their parents, including takingthem to creative and social activities for their mental wellbeing as an act of what Lynch (2022) calls 'love labour':

"For me, it's trying to be there as much as I can be, both in a practical and an emotional sense for them."

Care workers confirmed that, in their experience, older people prefer to receive support from familiar people such as trusted family members or care professionals they know.

"... they want the same person, the person that has a relationship with them and cares for them ..."

"... 9 out of 10 times, you've people with family members that really want to help, they want to beinvolved ..."

But the next comment reveals the complexity of caring for older people within a family context, e.g. regarding which family member takes responsibility, who lives nearby, who is aware of the care needs, what is the natureof their relationship with the relative and whether they are an older person themselves. An experienced family carer, who had cared for her parent and was now planning for her own future, expressed concern about her sister who is in cognitive decline:

"I certainly don't want her living with me here. She's very contrary and very cranky. So, I couldn't, wouldn't be able for it."

Care professionals relayed accounts of some families that relinquished responsibility for the care of their older relatives to the workers, or even exploited a vulnerable older relative. A service manager expressed the viewthat more and more families were doing so and emphasised that, in this context, workers needed support with demarcating their duty of care:

"Families are stepping back .... The HSE or anybody else, they're not here to run the lives of everybody else. That's a family's job to take that first responsibility and we assist, and we can't do everything. .... Otherwise, you'd just wear yourself out .... And you do have to walk away. Otherwise, you'd be totally burnt out. I have seen it so often."

4.2.3 Suitable Housing and Living Arrangements

The last topic in this theme comprised the practical aspects of people being empowered to take responsibility for care planning, such as the importance of houses being designed for universal access, alongside challenges in relation to financial and professional capacity to take on housing adaptations or a new build. Some former family carers discussed future proofing their home, and the need for joined-up advice:

"my house is sort of geared towards somebody who is a bit disabled because I had my mother a lot of time on a wheelchair, and I have a walk-in shower ... and a slope coming up to my back door .... a huge, big area to walk around in my kitchen .... if my time comes, I'll stick it out here as long as Ipossibly can."

"... I downsized. I built a new house whereby I have my main bedroom .... downstairs. Everything downstairs with a big walk-in and my priority with the architect kept being 'is this wheelchair accessible?' .... I was future proofing, but I didn't know enough because I now have a garden that I'mthinking to myself, 'I'm never going to be able to keep that'."

The following person looking to their future had not taken action yet:

"my house, I don't know how I'd ever get in or out of it ... because of steps and stairs and slopes and narrow doors."

A national health programme co-ordinator highlighted that not everyone can afford an architect, indicating a role for the State to support older people with accessing the necessary expertise or financial support to modify their home, "so that they're able to stay downstairs ... and within their own environment."

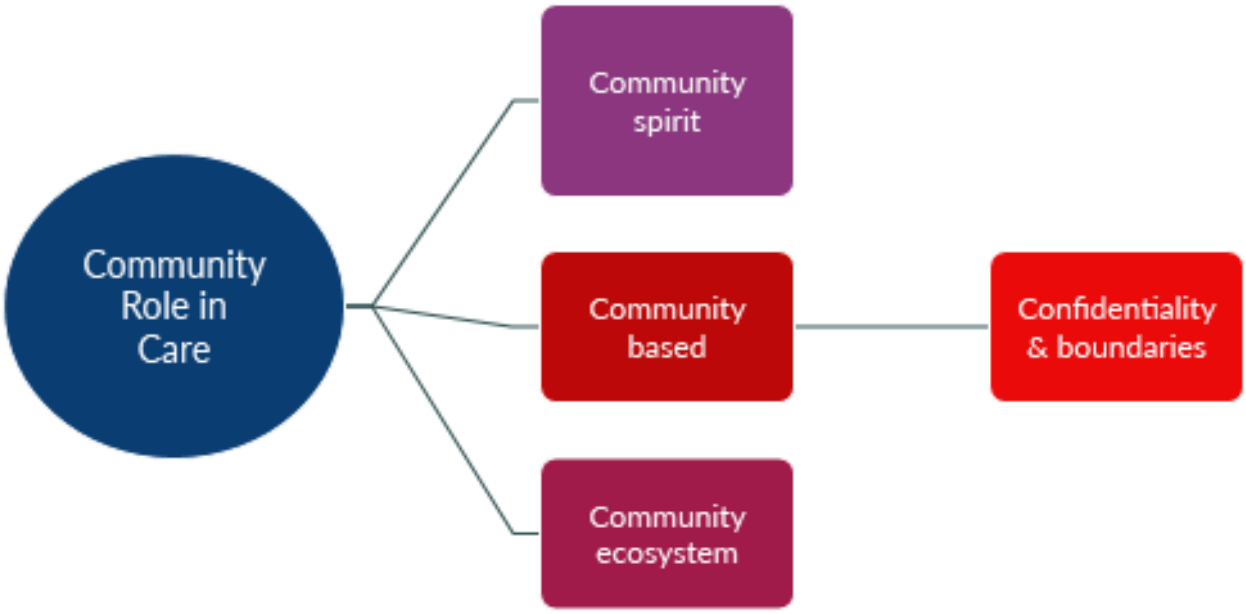
There was also interest in exploring alternative living arrangements, other than the family home or nursing home, as part of a wider suite of residential options. One person wondered about the concept of shared living as follows:

"the Japanese model of a number of people coming together and forming a community. .... maybe three or four people who have similar values being able to have a property that's adapted and that allows for people to live. .... just in the same way as you have independent living centres orhouses for adults with disabilities."

4.3 Community Level – Community Role in Care

In this section, the focus turns to the next level in the social-ecological model, that of the 'community'. At this level, three themes were identified. They relate to the local geography of being 'community-based', the local culture as captured by 'community spirit', and how geography and culture coalesce through spatial and relational proximity to manifest through local relationships and collaboration (Figure 4-4). This reveals the way in which 'responsibility' for care extends beyond one's immediate close relationships and through local social networks.

FIGURE 4-4: THEMES OF THE 'COMMUNITY' LEVEL.



4.3.1 Community Spirit

Community spirit can be understood as the integrated outcome of supportive human interactions and relationships, and the sense of sharing common purpose and being able to access mutual support among locals in a particular place. Community spirit indicates social cohesion or solidarity across a population and is acknowledged in the

community development sector as 'social capital'. One advocate for ageing supports indicated that it varies across communities:

"you get [mutual support] in really strong communities where there's that whole sense of identity and people look out for each other, and you get it in some rural communities, you get it in some urban communities."

One rural dweller noted the existence of community spirit in their area, where they felt assured ofsupport from fellow locals:

"Well, if I couldn't drive .... I know that somebody would take me shopping .... we're lucky in having a very good community group that would step up, I'm sure."

The following resident of a city suburb held a contrary viewpoint based on their local experience:

"There are loads of new people now have moved in, young people with families ... and they are notinterested in old people around here at all .... there's no community spirit ..."

4.3.2 Community Based

Mutually supportive relationships or social capital can develop and grow when people have *opportunities to meet and get to know each other* in a familiar, comfortable environment. It happens when friends gather in the private domain of their homes, and it can also happen when locals meet in everyday public settings such as the local shop, café, post office, or community centre to weekly religious services or annual festivals. The desirability and benefits of care services being 'community-based' so as to enable 'ageing in place' emerged in the focus groups. 'Community' is the tier of the social-ecological framework in which the research participants began to link the notion of 'care' with the idea of a 'service'. At this level, they imagined facilities that would improve people's access to local care as simply being part of a well-functioning community "like the community hall, and the church and the school ..."

One island resident described their local care facility in such terms:

"it's formed of little houses so it's almost like a supported living with a common area with nursingstaff there and the Primary Health Centre is run out of the place there too. So, for people on the island who may need to move into it, they are in a familiar environment already and they are meeting with the people who they would have met with growing up and are on the island. I think it makes ... the transition easier .... it's very much of the place."

The following service manager took the idea further and wished to see an open-door care facility in every town for all demographics, like a drop-in Community Centre of Care:

"... where you can walk in, that it's not a case of 'you have to be registered with us' ..."

The research participants' descriptions lie in stark contrast to the ongoing economic trend of rural restructuring in Ireland, where services are closing down or being withdrawn from villages and smaller towns and becoming concentrated in larger urban centres. Such service rationalisation leaves affected residents increasingly car-bound or dependent on online services. Both, in turn, reduce opportunities for casual face-to-

face social interactions among neighbours through which relationships that foster mutual aid might grow across a community. This trend weakens the social fabric of communities.

Urban concentration is also reflected in the design of home support services. For example, it is evidenced by care workers not being adequately resourced for travel time and related expenses to drive between rural clients. In the terminology of Doughnut Economics, such worker terms and conditions indicate a home support service designed for profit (or from the perspective of the public sector, to minimise costs) rather than for the purpose of serving those who give and receive care. The following care advocate identified that unmet needs resulting from the for-profit model are the gap to which a community-led and community-based service, such as a co-operative could respond (this point is developed further in Section 5.3.3):

"If you're living outside of a main population area … If somebody isn't getting paid for their travel time and ... travel expenses ... it makes sense that you would look at a community and see is there scope to set up a co-operative within a community setting where you've got a defined geographical area ..."

Community spirit, where harnessed and organised by community champions and local groups, and in a process facilitated by an experienced and appropriately resourced local development sector (e.g. Local Development Companies), can support the development of bottom-up responses to unmet needs. This study documented two examples of successful community-based home care services that have emerged to serve gaps in the market. A community response to a local need is the origin story of RHS Home Care in the north-west. So too is the establishment of Connemara Care, that was developed with the support of FORUM Connemara, the Local Development Company in that region.

4.3.2.1 Confidentiality and boundaries in community settings

While some participants expressed a strong preference for local people to provide care, it was also acknowledged that the local context presents challenges related to the privacy of the care receiver or in terms of the work-life boundaries of the care worker. This subject was broached by several participants, including the following family carer:

"people mightn't want somebody from their own community coming in, providing care ... [e.g.] 'I don't want them knowing my business' ..."

Examples of other organisations, which operate successfully at a local level, were cited to counter these concerns. For example, credit unions are co-operatives that are organised locally and run by people in the community. They provide a financial service and, as such, handle highly sensitive data in relation to members' financial circumstances. Those involved in running credit unions were described as "honourable and ... they don't go around talking about everyone else's business". Other examples given included charities, such as the St. Vincent de Paul, where volunteers maintain their clients' confidentiality.

A challenge envisaged for frontline workers in community-based services was the issue of maintaining boundaries between one's job and private life. As illustrated by one participant:

"I'm thinking of the school secretary ... She lives in the same community as the school. People will bedropping envelopes into her house late at night [laughs] because she lives in the area and they're just saying 'oh, I'm sure she won't mind ...'. So, it's just thinking of clear boundaries for the person who's going to be delivering the care that they can mind their own self-care as well."

Another participant concurred:

"That was very much borne out during COVID times when the restrictions were so strong that people in the locality were very much aware that their neighbour, who was a care worker within the nursing home, was getting to see, to be with, and even being able to hold the hand of their loved one, and they weren't necessarily being able to. The nursing home had to set up even tighter pieces around communication with the families to say, 'please don't put the people here who are working or care staff under further pressure around asking them about their loved ones outside of the nursing home'. So that when they were down shopping ... they weren't being asked about the loved ones, understandable as it was that people were concerned and wanted to know."

This indicates the role of community buy-in and understanding of boundaries as might be achieved through a multi-stakeholder partnership approach to developing and running a community-based service. It also highlights the importance ofn for training and achieving high standards in confidentiality and discretion among all those involved in delivering a home care service.

4.3.3 Community Ecosystem

The preceding material outlines that being 'community based' increases the opportunity for social interactions. In turn, social interactions can build relationships of mutual aid among residents that are encapsulated in the term 'community spirit'. As one care co-operative worker appealed:

"Just bring the community together on [a] voluntary basis and just get back to community. That's where life worked better for people, wasn't it .... you could go down the road, you could call on a neighbour."

It stands to reason that a community-based care service has the potential to be interwoven with such local mutual aid relationships. One service manager noted that being a community-based care service with a non-profit ethos and voluntary board meant that local people knew "what we stand for" and their organisation had long-standing relationships with local businesses. In turn, the care service benefitted from the resulting goodwill and support for its work within the community and among its suppliers.

The benefits can flow in both directions. Being embedded within such a community ecosystem may improve the quality of the care experience. The following service manager explained how relationships between a local service and older residents receiving home care, some "for 20 years" led to "continuity of care, having the same people going into them".

A representative of an existing community and voluntary sector care initiative provided an example of how being embedded within and networked across a community, including through its relationships with other complementary services, resulted in a more holistic care service overall:

"It's about delivering the best service we possibly can and because we're a community-based organisation [linked to a local development company] there's an awful lot of cross-over. For example … say [the care company] have somebody [who] has just started care, they're after coming out from hospital and they need Meals-on-Wheels, they're on to us straight away and we organise the forms ... So, it's those community, embedded contacts."

In another illustration of the importance of the community ecosystem in terms of care, a care worker provided a frontline example of helping an older man in an urban area who lacked family support and needed more care. The care workers received approval from their community-based organisation to advocate on his behalf. They liaised with the client's local GP and PHN to obtain the necessary clinical assessment and resulting referral that secured additional care hours for him without delay.

Advocacy on behalf of care clients takes time and effort. Across different services or even between different departments within the HSE, it calls for communication, co-ordination and collaboration among associates and colleagues, which is where mutually supportive professional relationships and working towards a shared purpose can make a difference. The following HSE home support service manager described how they worked closely with the community-based nursing team in their local area:

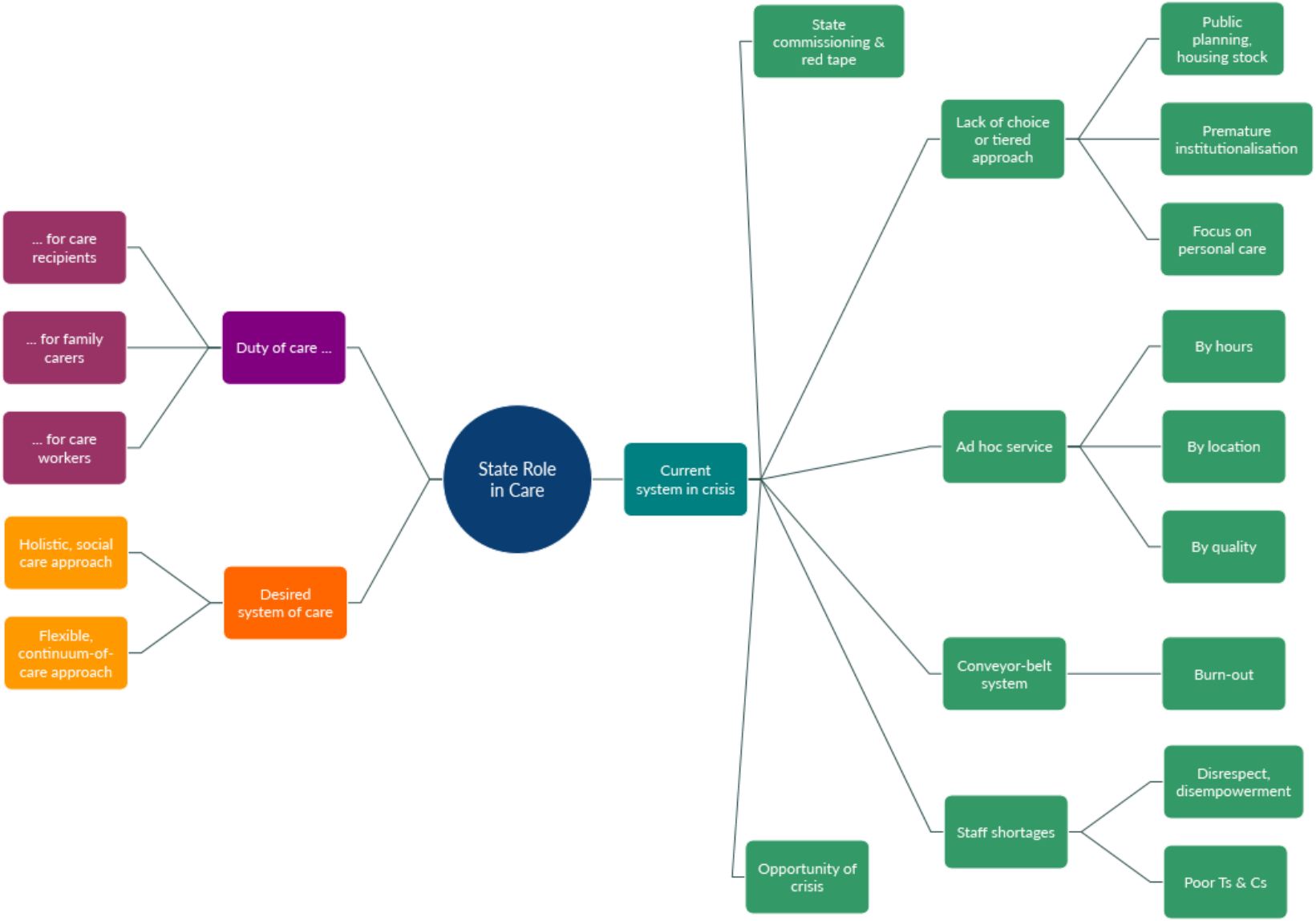
"Case holders are the public health nurses and the community registered general nursing. .... They run a seven-day service. If they have a HCSA [health care support assistant] under their remit working at the weekend, they're directly managed by the nurses. ... we don't do weekends, but in the case of palliative care, I will put in HCSAs towards the end-of-life ... if that's what the family want. .... But I have to strike a deal with the public health nurse that she manages that situation because she'll be in there over the weekend (or the palliative care team), and that's their job to do that."

Thus, in terms of its standing among local people and businesses, in terms of being known and trusted by its clients, and in terms of how care workers and managers advocate for and collaborate with other local professionals in the health sector on behalf of clients and their families, we might infer the following. A community-based service that is embedded in a local area and interwoven within an ecosystem of community relationships is well-placed to benefit from and contribute to 'community spirit' through their own practice of care.

4.4 Society Level – State Role in Care

The final level of the social-ecological model is that of 'society'. Analysis of the focus group transcripts indicated that much of what the research participants discussed ultimately led back to the State and its overall responsibility for the care system. It became clear from the focus groups that the State holds a dominant position in the care of older people and the researchers identified three overarching themes (Figure 4-5). The foundational theme is that of the State's 'duty of care' for the givers and receivers of care in Ireland. The second theme is the complex picture that emerged of the 'current system in crisis'. The third theme is the 'desired system of care' as participants envisioned a better future for care recipients, family carers and care workers, and by extension, Irish society as a whole.

FIGURE 4-5: THEMES AND TOPICS AT THE 'SOCIETY' LEVEL.



The State controls the care system. The level of 'society' is the tier at which policies are developed, legislation is enacted, and regulations are set out, all of which determine how much and in what ways resources are invested in the care system. These in turn shape the lived experiences of care within families, organisations and communities. Herein lies the power to foster or to hinder care that nurtures.

4.4.1 Duty of Care

In the first overarching theme at Society Level, participants outlined that the State has a duty of care to three key stakeholders: care recipients, family carers and care workers. At the CO-AGE webinar, Emma Back (2022) of Equal Care Co-op in Yorkshire declared that in the UK, neither those receiving nor those giving support were cared for within the existing system:

"The problem is that the care industry isn't caring. .... Why are the most important people in the caregiving relationship being systematically exploited and ignored?"

4.4.1.1 Care recipients

In terms of care recipients, focus group participants expressed a lack of confidence in the State's capacity to meet its duty of care towards older people. In direct contrast to the State's approach to care for people with disabilities, where there is "this massive move away from congregated settings ... we still have big residential care centres [for older people]." Two key concerns among those planning for their own future care were the quality and affordability of care in the face of uncertainty, such as how long they might require care in the future, or whether adequate public finances would be available then. This uncertainty left people concerned for themselves and their families, and eager to explore community-led alternatives like care co-operatives. In the following quote, one participant planning for their future was emphatic that the State needed to meet its duty of care for all ageing residents:

"We are in our old age. We have all contributed to society. We shouldn't be just a problem. We have lived and worked and paid taxes and reared children ... You are entitled to care, whatever it is, without having to apologise for it."

Due to this lack of confidence in the State's capacity and approach to care service provision, participants were eager to learn about alternative models that offered older people and their families more influence and greater choice in the type of care available. They wanted those alternatives to value the experience and insights of older people, rather than merely seeing them as passive recipients of care.

4.4.1.2 Family carers

Turning next to the State's duty of care for family carers, focus group participants provided evidence of its failure in that regard. The manager of an advocacy organisation explained that family carers who were ageing themselves were struggling to maintain their home environment since the State withdrew domestic tasks from the responsibilities of HCSAs (formerly known as 'home helps'). In addition, the State does not fund adequate family carer respite, which can cause distress and compromise safe care:

"[family carers are] struggling, just even to care for themselves and then care for a loved one, because they have reached a point in their lives where things aren't as easy,

whether it's because of mobility or whatever. .... hygiene within the home is such a massive issue and there's no help with it. And theycan see the standards dropping and the things that they were always able to do easily but can't do now, you know? And that can be very distressing for some people."

"... we try to provide as much respite, but the Section 39 budget is very small ... you're waiting forsomebody to die to free up some hours. And that's terrible for so many families where respite is what enables them to continue to care safely for their loved one."

Being a family carer has a negative impact on one's income and so the State offers social welfare supports such as the means-tested Carer's Allowance. But the following family carer described their experience of the support as contingent on them losing their own financial independence, and as degrading:

"... when I [returned from overseas] because I had ... some savings, the government said, 'Sure, youcan stay at home and care for your father and free us up on the dime of putting him in a nursing home.' ... but they won't pay me the Carer's Allowance until I've literally gone through most of my savings. And then I become a burden on the State, and emotionally and mentally beaten down."

Hearing these testimonies, another participant reflected on the compassion demonstrated by familycarers in contrast to the lack of it shown by the State:

"I think Irish people are absolutely fantastic, remarkable how they care, how they work as carers. .... The Government .... They're living off the goodwill of the people who can care for [family members] or who aretaking it on or changing their jobs or moving home."

4.4.1.3 Care workers

Lastly, research participants highlighted the State's duty of care for care workers. A national health programme co-ordinator summarised this priority as *care for those who care for others*. As already outlined in Section 3.1.4, the care workers who took part in this study had professional experience in the care of older people from a range of institutional settings, specialisms and organisational models. Some also had professional experience in childcare, and many were now or had been caregivers in their own families – caring for their parents, partners and/or children.

Caring as a vocation, a calling in life that went above and beyond an occupation, was a theme that emerged from the focus groups as demonstrated by the following quotes from two family carers and a care worker:

"caring is a vocation. It's not just anyone you can plonk into that role .... caring is particularlyspecial because other people are vulnerable, and they need this."

"... what they do is so precious .... they're so committed ... I can see that with the home care workersthat are going into Mom. So many of them try to bring a bit of cheer with them as well as practical help."

"... I've always been naturally caring. I've been a parent for 15 years, single mother for eight of thoseand when I got to a time where I had to look into starting back work, I just looked for something in acaring role ... and I never really looked back."

This sense of certain people having a vocation for caregiving, where care workers "go the extra mile ... give extra time, give extra hours" is evident in the following statement from a care worker who, despite being her family's principal income earner, prioritised her duty of care to the client and to their household over her own pay and travel expenses:

"You can't leave when someone is dying .... you're not leaving them high and dry, you're not .... if you get a good healthcare assistant, she will go back, or he will go back. They don't care whether you're getting paid double pay, single pay .... They don't care about their petrol money. They're committed to that person, to the household. And that's a good carer."

These points reveal the vulnerability of care workers to exploitation by an uncaring State. As people with a vocation to care for people who need support, as experienced caregivers in their own families, as breadwinners on whom their families financially depend, care workers may continue working in a care system inconducive to their own wellbeing, sometimes to the point of physical injury or psychological burnout. As Aoife Smith (2022) explained in the CO-AGE webinar when setting out the origin story of the Great Care Co-op:

"We needed a paradigm shift. One that would invest in the workers in order to generate good care. And we were basing it on a human rights and equality framework."

Age Action's representative agreed that a rights-based approach would benefit both those who give and those whoreceive care:

"Like building a relationship, if you're taking a rights-based approach, there's the rights on the two sides. .... it's not really a coincidence that an organised system that's particularly conducive to supporting the rights of workers is also best for the rights of the persons the workers are working with."

4.4.2 Current System in Crisis

The previous section emphasised the State's duty of care for those who give and receive care. It also shared evidence where the State was failing in that regard under the current system. This section turns to the second overarching theme at Society Level by assessing Ireland's current care system and the role of the State as documented through the testimonies of the focus group participants. They illustrated a system in crisis in different parts of the country. Material gathered from the focus groups that related to the theme of the current care system being in crisis grouped into the following six topics (Figure 4-6; *see also Figure 4-5*).

As GCC co-founder Aoife Smith (2022) outlined in the CO-AGE webinar when explaining the motivation to establish the care co-operative:

"it was very clear that the model was broken, that it wasn't working for carers, it wasn't working for families, and it wasn't working for individuals."

The following hospital-based worker put it in stark terms:

"the current system that we see operating on a day-to-day basis is at absolute crisis and it's breaking down .... I can certainly see from the frustrations ... from families with respect

to care agencies, and ... from a hospital perspective, that the model is at breaking point."

FIGURE 4-6: THE CURRENT CARE SYSTEM IN CRISIS.



4.4.2.1 State red tape and commissioning

For the individual or family, accessing home-based care or help with house adaptations from the care system involves navigating public administrative systems and their procedures. A local authority employee referred to the challenge for people to negotiate county council grant applications such as the Housing Adaptation Grant for People with a Disability:

"It's very bureaucratic. You have to fill out your forms and send the application into the Council before the Council comes and responds."

Using the Fair Deal (Nursing Homes Support Scheme) as an example, family carers recalled theirnegative encounters with the HSE's administrative processes:

"... getting through this bureaucratic red tape is just mind boggling."

On the service provision side, the State's commissioning process came in for criticism too. The HSE's process of allocating care packages to contracted providers was described as "a barrier to providing proper care for clients". For example:

"we'll say 'Mary' is approved ten hours of home care a week and that [notice] goes to 75 providersand the first person to say 'yes' gets that package. It's 'fastest finger first'. That model does not workbecause ... the private companies have someone sitting there pressing 'yes', all day long. They take the 10 hours. Then two weeks later, they realise, 'Oh, I actually haven't got the carer to put in that 10 hours' and they send it back [to the HSE] and it's just recycling older people's hours over and over again, and it leaves the older person without care and without support at home ..."

These quotations reveal how people experienced the bureaucracy of the care system as complicated and inefficient. It shows that if the State's administrative processes do

not prioritise the care needs of the older person, they may become another barrier for those trying to access or provide support. If not addressed, the same issues are likely to negatively impact any future statutory scheme for home care too.

4.4.2.2 Lack of choice or tiered approach

In their testimonies, participants evidenced the lack of choice or lack of a tiered approach currently due to the State's narrow focus on personal care in home supports, the premature institutionalisation of older people due to resource and service limitations, and the wider role for planning and building regulations.

4.4.2.2.1 Narrow focus on personal care

One family carer described how the medical model of home care (experienced as rigid and standardised) did not offer the relational social care she sought for her father's actual needs:

"we only got one hour in the morning, and [the care worker] was very task driven. It would get dad up ... but with the dementia, really what he needed was the cognitive stimulation. He could still get himself up, he could still shave but she was so focused on getting him up and getting him shaved and all he wanted to do was to have the bit of chat."

Instead of the current medical model, a home care service manager argued for a *social care m*odel:

"people living in their homes are not patients, and they shouldn't be treated as patients. It should be more holistic .... personal care ... is under social care. It is not under nursing because it is not a medical need .... And we need to make that distinction".

4.4.2.2.2 Premature institutionalisation

Participants provided evidence of insufficient resources for home care to support people to age well in place and for hospital patients to be safely discharged home. Such resource issues and the narrow focus on personal care is compounded by the lack of options other than being cared for at home or entering a residential nursing home. A family carer described the injustice of the State's approach resulting in "the extremely scattered, unimaginative parking of people in homes" and called for a "halfway point".

A nursing home is rarely the preferred option. Care workers and service managers encountered peoplewho wished to remain living in their community rather than moving to a nursing home:

"After COVID, people do not want to go into a nursing home .... People want to remain at home. It ismore cost effective in every sense and leads to longer life living at home."

"I worked in continuing care for a long time ... and I see the effects of people having to come into long-term care, which isn't very nice a lot of the time for them because that's not what they want."

Two family carers described how a relative and a neighbour were compelled to move from their homes to a nursing home due to shortfalls in resourcing and the lack of a wrap-around approach in the current care system. Both moves were contrary to their own or

their families' preferences. The following quotation paints a vivid picture of a life changed utterly after moving to a nursing home:

"it wasn't possible for them to give her the people into her home to give her that amount of time. She needed cooking, shopping and bathing help, but she really wanted to stay at home .... So, she moved to [the nursing home] ... and she has her own room, but 99% of the people who are there have dementia. She's incredibly smart ... you wanna know what's happening in [the community] and the wider world, she knows about that. But she's becoming increasingly isolated. She's got people trying her door in the middle of the night and walking in ... there's gotta be some kind of halfway point, of her having community, her own privacy, people that she can talk to and interact with."

Negative perceptions of nursing homes included insufficient staff, inadequately trained staff, being disconnected from one's community and a lack of stimulation in the residential environment that left people in "fear" of that option. Some people expressed the hope that they would die before needing either long-term hospitalisation or a nursing home, including opting for euthanasia if institutionalisation became the only option:

"Once you go into a nursing home, you're gone. Never to be seen again, largely."

"I really don't want to go into a nursing home and just live out my days looking at a budgie or looking at a television."

"I think I'd rather go to Switzerland and buy my tablets and come back home and have a nice bath and a glass of wine, if I felt that in 20 years' time or whenever I am looking at that variance of care and support. I'd rather just take myself out. I think it's inhumane ..."

A minority of participants had themselves (or knew of people with) a positive perception of nursing homes based on experience. An interlocutor, whose two older relatives "both finished their days in nursing homes" (one of whom had Alzheimer's and no longer recognised or felt safe in their own home), recalled that it was "as beautiful an experience for both of them as you could possibly hope for." One family carer's parent was unconcerned by the future prospect of moving to a nursing home if the need ever arose because of their "familiarity with that setting" due to their own parent's positive experience in one.

It is clear that a nursing home may be the preference or right option for some older people. Thus, nursing homes would remain part of a more diversified care system in Ireland. A diversified care system could help to change the generally negative public perception of nursing homes too. Their poor standing currently can make the decision by a family difficult when a loved one is unable to remain at home safely. Relatives may experience personal guilt or attract criticism:

"... that was something that we struggled [with] ... 'will people think we were so uncaring that we put her into the nursing home?' ... she really wanted to go. She was afraid in her own home."

4.4.2.2.3 Public planning, housing stock

People preparing for their own futures recounted experiences of seeking to build a new, smaller house in their garden. One participant felt supported by their local authority and

had succeeded in downsizing, while another considered that their county council obstructed such development. In the following quotations, two older participants highlighted the State's responsibility through the public planning system to future proof current new builds and to ensure a diversity of housing stock in local areas:

"it's absolutely ridiculous that we are still allowing houses to be built that don't have wide enough doors for wheelchairs. It is so easy and so simple to do at the planning stage and yet it's not done."

"I wish they had smaller houses that we could move into and have plenty heat and well insulated ..."

Awareness is growing around the need for diversified housing stock. The National Disability Authority (2015) compiled 'Universal Design Guidelines for Homes in Ireland' to inform public policy in light of the ageing population and the likelihood of someone with a disability going on to live in a new build, or a resident developing a disability over their lifetime, as well as to offer practical help to home builders. Universal design is "the design and composition of an environment so that it can be accessed, understood and used to the greatest extent possible by all people regardless of their age, size, ability or disability" (ibid., p.5). The Age Friendly Homes website (a joint collaboration between the Departments of Housing and Health, together with Age Friendly Ireland and The Housing Agency) is another resource that brings together information for older people to adapt their home or downsize along a continuum of housing-with-care (Age Friendly Homes, 2021). It also covers such matters as public policy, planning and building regulations.

However, the lack of choice or a tiered approach remains a characteristic of the care system for now. The State's response to home-based care focuses on people's personal care needs using a *medical approach*. It treats the older person as a patient and does not offer the other supports that people often require in order to remain living at home, such as help with shopping, cooking, laundry or house cleaning. Additionally, when an older person moves to a nursing home, they leave behind multi-generational communities and live out their days among other older people. Due to the predominance of this primarily medical and institutional approach to elder care, the State is failing to consider the suite of older people's needs in terms of human authenticity and attachments (as outlined earlier in Section 4.1). Instead, participants called for diverse options informed by consultations with older people about their requirements and their preferences, including for a range of housing options within their communities. The State has shown an intention to respond to the need for a more holistic approach through the integration of care services and more equitable access to them under Sláintecare, the unfolding reform of the healthcare system.

4.4.2.3 Ad-hoc service

The third topic that participants highlighted as an issue with the current care system is its inconsistency in terms of where supports are available, when supports are available, and the quality of those supports. People working in home care, advocacy for family carers and in Government health programmes referenced the following anomalies in terms of support location, hours and quality.

4.4.2.3.1 Location

One example of geographical differences is that direct provision of home-based care by the publicsector is not country wide. For example, in County Dublin, the HSE does not provide any direct home support services itself. Instead, it contracts the work out to various private or community and voluntary care providers in local areas. According to one family carer and advocacy worker, a second example is Consumer Directed Home Support (CDHS), designed so that an older person will be able to choose their own care provider from those approved by the HSE. Her experience was that CDHS is not available inher county, even though the HSE confirmed to the researchers that there is provision for CDHS nationally.

Service provision can vary between urban and rural areas too. One reason is due to inadequate compensation for HCSA travel time and travel expenses, which are greater in rural areas due to their dispersed populations. Rural services have critiqued the State's Resource Allocation Model for failing to fully account for the impact of rural geography on the costs of service provision (e.g. Crowley, 2018).

4.4.2.3.2 Hours

Some people require care daily and, while care workers may continue to provide support over theweekend, other services are closed. As the following care professional pointed out:

"people just don't live from Monday to Friday, you know? ... they have the same needs and wantson Saturdays and Sundays ..."

4.4.2.3.3 Quality

Participants also noted the issue of variability in the quality of local services, including in regard to how services aremanaged. While care workers were praised during the focus groups, some participants raised concerns about the quality of staff training and staffing levels. One care worker was concerned to see teenagers being hired in their area to provide home care:

"They're 19 .... they're only kids. They shouldn't be getting employed because they actually don't know what the needs of a 90-year-old lady is, or a 90-year-old man."

4.4.2.4 Conveyor-belt system

The fourth topic that participants raised in relation to the current care system in crisis was its similarity to a conveyor belt and how it can lead to staff burnout. This was reflected in the intertwined negative experiences of carerecipients and care workers described in the following testimonies:

"It drove me mad, just watching the lack of care, the conveyor-belt care that you have to give just tofunction on a day-to-day basis ... You'd go in [to the nursing home] and there'd be massive pressure on you to get Mrs. A done in 20 minutes and then Mrs. B might be calling ... And there was no psychological care at all. It was just the practical element of it. And if you did go the extra mile, your colleagues would be having to pick up the slack and then they'd be looking at you because the management was barking down their necks, and it was horrible."

"I did work for another home care provider and when I started with them ... 12 years ago, it was fine ... But as the time went on, they got a tender for HSE calls and it became increasingly obvious that they were just interested in getting the money in. They didn't care, once they had a carer in a house …. it didn't matter who the carer was. It didn't matter what care was being provided to that client. Very, very, very frustrating."

"I might have up to 15/16 different clients in a week. It was crazy and you were chasing your tail all the time to try and get to the next call."

These issues are not unique to Ireland. The care system in the UK was also described in terms of a conveyor belt by Emma Back (2022) of Equal Care Co-op in the CO-AGE Webinar. She went further, saying that the care system was deliberately designed to function as a conveyor belt:

"It could be anyone coming through the door, usually very short calls, often late or early, not knowing who's going to be arriving at any one time, and a real diversity ... of care and support workers who never really get to know you and are always thinking about getting on to the next person, doing the notes, etc., and you're a list of tasks to be ticked off. And that is how the apps are built, that is how the system is commissioned, that is how success is measured."

4.4.2.4.1 Staff burnout

In such a conveyor-belt care system, care recipients experience suboptimal care and care workersexperience poor quality employment, sometimes to the point of burnout. In the following quotations, two care workers described the stress and health impacts of working in a conveyor-belt care system. They subsequently left those positions.

"It got to the stage that I was starting work at 8 o'clock in the morning and I wasn't finishing till 10o'clock at nighttime .... And we had to work weekends, with generally not much extra pay ... And itactually started to impact on my health."

"It stressed me out massively. And it's just not the type of person I am. I was there to care for people completely. And there was just such a massive hole in it, you know? ... [I said] '... I'm done. I can't do this anymore'."

A family carer shared a friend's experience that showed how the conveyor-belt care system drove away nurses too:

"... she's a nurse ... and I think that's the problem ... you're in a caring role and you're not reallyallowed [to] care because you're under a schedule .... So, she stopped working for the nursing home because she felt the pressure was too great and she couldn't give the time to each patient that theyneeded ..."

4.4.2.5 Staff shortages

The fifth major concern with the current system of care was its staff shortages. As previously outlined in Chapter 2, approximately 6,400 people who had been approved for funded home care by May 2023 were waiting to receive these services due to staff shortages. Focus group participants provided their own evidence of staff shortages. Hospital workers described patients not being able to return home after rehabilitation because there were insufficient home support staff in the community. Home support service managers described not having enough staff to meet increasing demand in the

community. A daughter relayed being unable to secure carers to support her ageing mother at home.

IHREC-funded research in 2014 conducted with over 100 care workers across the public, private and not-for-profit sectors in Ireland to understand their concerns identified cultural and management issues in the care system, including failure to recognise the value of care, the care system as a conveyor-belt, inadequate staff training/support, poor terms and conditions for care workers, disempowerment and fear among workers and clients (Smith, 2022). The current research study indicates that the same issues persist nearly one decade later and so it is unsurprising that the care system is experiencing staff shortages. Two issues related to the valuing of care workers emerged in this study: a culture of disrespect and disempowerment towards care workers, and the poor terms and conditions of their employment.

4.4.2.5.1 Disrespect, disempowerment

Care workers in the focus groups elaborated on the disrespect and disempowerment that they experienced in the care system. The quotations below from a hospital-based care worker, a community-based care worker, and a family carer demonstrate how a care system that fails to respect the experience of care workers does not serve the interests of care recipients either. Care workers described being excluded from inputting to care plans, being prohibited from communicating with one another, and their concerns for clients being disregarded by their own office. Over time, they grew disillusioned with the system:

"we as healthcare assistants work so closely with [clients], nine times out of 10 we know probably more of their needs than anybody else. But our part is not acknowledged .... Because we don't have that say in what is happening on the ward or with the care plans or with the patients or their needs. .... I as a carer can see exactly what the patient or the client needs at that specific time. It might be something so insignificant, but it makes such a huge difference to them. But nobody will listen to me .... it's very disheartening. I enjoy my job. I give it 100%. But there are some days you are so disillusioned, and you'd say, '... why do I bother?'"

"I had no say in anything ... We had people coming in from the office (who had no experience in home care) doing care plans and assessing what the care needs for that person might be and [me] literally not being listened to and none of my experience being taken into account ..."

"We weren't allowed talk to other [other] carers. I didn't know anything about them. We weren't allowed share any information ... Everything went through the back office. And nine times out of 10, what you reported to the back office just wasn't acted on. Because you'd go back into the client the next week and ... it would be the same problems."

A family carer explained how the disempowerment of care workers also reverberated within the families with whom they had established strong bonds over years of caregiving:

"we've had [a HSE HCSA] since 2016. She actually came to look after my mother, who died very quickly after that and then stayed for my father. They have a new manager and the manager's now saying, 'You no longer have specific people that you take care

of. We'll put you wherever we need you, wherever we want.' And she was really upset about that. I was really upset about that."

4.4.2.5.2 Poor terms and conditions

Care workers' terms and conditions of employment can be used as an indicator of the employer's regard for them and their work. The research heard of low pay among care workers in the private sector and of working drawn-out shifts across the day or working weekends for little extra pay. It also became apparent that terms and conditions differed across the private, non-profit and public sectors. Two service managers in the non-profit sector, who are both active in advocating for improvements in the care system, discussed the poor treatment of care workers in the private sector in particular. One reported that they are attracting care workers from the private sector as a result. Another described some of the poor terms of employment in the private sector as follows:

"you could have eight calls a day and it might take you two hours of travel time. You don't get paidfor the two hours of travel time."

4.4.2.6 Opportunity of crisis

Taken altogether, the problems affecting the current care system, encompassing red tape, lack of choice, an ad hoc service, conveyor-belt system and staff shortages, paint a picture of a care system that is not fit for purpose. In the face of so many issues, social innovators are responding to the need for change. For instance, the poor treatment of migrant care workers drove the establishment of the GCC:

"They literally just said one day, 'Why can't we do this for ourselves?' And that's where the seed was."

Smith (2022) saw the opportunity to innovate not just locally but in terms of 'systemic change' nationally:

"We will not get to where we want to be with the model that we have at the moment .... We will notattract carers in to work with it. So, there is that opportunity now .... The broken home care system at the moment and the recognition of it and the awareness of it means that there's room to innovate within it."

4.4.3 Desired System of Care

In the third and final overarching theme at Society Level, participants in this study imagined the type of home care they wished to see in Ireland. Their desire for a better care system into the future was often what had motivated them to take part in this research study. They called for a holistic social care approach to address the diverse needs of a care recipient at home with wrap-around and customised supports. They also outlined an approach that integrated the current options of continuing to live in the family home or residing in a nursing home with an expanded suite of community-based support services and living arrangements along the spectrum in between. And they wanted a system that cares about those who give and receive care. Smith (2022) had described a similar starting point for the GCC, which sought:

"... a systemic change model that would look at having great care and great jobs together, that the two were intrinsically linked."

The focus group participants agreed and envisioned an integrated care system across the lifespan. Together with older people, a lifecycle approach to care would encompass childcare, people living with disabilities or complex needs, along with respite for all of their family carers. This vision complements national mental health policy which also proposes the implementation of a lifecycle approach to wellbeing in Ireland (Department of Health, 2020).

4.4.3.1 Holistic social care approach in the home

Participants outlined the need for a holistic social care approach to home-based supports. A care worker described how, in the past, their duties did indeed include shopping and cooking. An older person planning for the future expressed their wish to be able to access social stimulation and help with cleaning the house. A family carer explained that their relative with Alzheimer's simply wanted someone to sit with them, but this option was not offered under the current medical approach to home care. Instead, they received help with dressing as this task was covered in the medical protocol, even though the older person could still dress themselves. A national health programme co-ordinator commended a holistic social care initiative in Northern Ireland that instead considered the diverse needs in an older person's life including their need for housing adaptations, access to transport and Meals-on-Wheels:

"the whole wrap-around to be able to enable that person, that household, to enjoy the best quality of life that they possibly could have .... that's the type of direction we will probably need to go."

The Northern Ireland local government initiative, called Maximising Access in Rural Areas (MARA), was a joint rural development and health anti-poverty intervention where older people were one of its target groups. Implemented by local rural organisations, it entailed a house visit to conduct a needs assessment and to make residents aware and then encourage them to avail of services, benefits and grants, along with follow-up support and referrals (Public Health Agency, Millman, and McCay, 2017). Its evaluation concluded that people's success in accessing diverse supports and benefits resulted in statistically significant improvements in their self-reported general health, social connectedness and quality of life (ibid.).

In one of the focus groups, a retired nurse recalled participating in co-ordinated outreach by the health service and local government in Ireland working together to support rehabilitated patients to return home from hospital:

"if we had patients that were from rehab ... we used to go out with, say, the occupational therapist and physiotherapist and the nurse, mostly, to see what they needed. And the Health Board or the [local council] used to do bits of renovations for them and eventually they'd get home."

These three examples shared in the focus groups, of the Irish care system in the past and the more recent Northern Irish initiative, share two features. Firstly, the process was led by experienced service providers rather than the individuals in need of help or their families. Secondly, it was co-ordinated across national health and local development or local government sectors. In the current care system, responsibility for accessing help has been increasingly divested to the individual or their family as a 'consumer' of supports. This requires inexperienced people to navigate the 'red tape' referred to

earlier, which is likely to privilege 'consumers' who are well-educated, more affluent and/or have greater levels of agency, while marginalising the most vulnerable. Individuals or families are left to liaise separately with different arms of the care system and local government, which is likely to increase the risk of duplication and delays due to a lack of co-ordination across and even within those sectors.

The kind of co-ordination described above is being trialled through the Sláintecare Healthy Communities (SHC) Programme. It is a cross-government initiative launched in 2021 to reduce health inequalities using a lifecycle and place-based approach to address local needs (Government of Ireland, 2023a). Led by the Department of Health, it is being implemented in a range of communities across Ireland through a partnership of local authorities and the HSE, together with community organisations such as Local Development Companies, Family Resource Centres and Community Co-operatives.[14]

4.4.3.2 Flexible continuum-of-care approach in the community

Ageing is a natural part of the life cycle characterised by changes in an older person's physical and/ormental health that call for modifications to the home or different living arrangements. And as seen earlier, the essential human needs for authenticity and for attachment continue to hold true in our older years.

Focus group participants, including those planning for their own care in the future, family carers, care workers and other professionals, identified that older people require access to a range of alternative options in terms of housing stock, living arrangements and local support services to be able to meet their essential human needs within multi-generational communities. In a 2019 survey of mature homeowners aged 55+ years in Ireland, which assessed people's willingness to downsize, while only 4% would be extremely or very likely to move house, a further 15-20% might be motivated to move if a suitable smaller home could be purchased *in the same area for a lower price* (Corrigan et al., 2020). A government initiative called the Age Friendly Programme is working towards the availability of a choice of different sized and affordable housing stock in local areas (Age Friendly Ireland, 2019). However, such housing stock remains limited and older people do not have many options in terms of financing a house move (Age Action, 2022).

Cullen et al.'s (2007) housing-with-care continuum shows the various ways in which housing and care supports can be combined as needs change with age, up to and including nursing homes. As already outlined, the focus group participants did acknowledge that nursing homes could remain an option for people with higher, specialised care needs or who expressed a preference for them, but only as one option among a range of alternatives. Economic analysis shows that it makes financial sense too for people to age at home or in supported housing in their community for as long as possible (Amárach Research,2016).

The following family carer and carer advocate envisioned the idea of a 'continuum of care' in terms of 'stepping stones':

[14] For example, Dublin City Community Co-operative Health Communities Project: https://dublincitycommunitycoop.ie/programmes/healthy-communities-project-north-east-inner-city/

"people's needs are constantly evolving and the options available need to also be evolving .... It could be a stepping stone. It could be an option .... the more variety we have, the greater the chances are that people's needs will actually be met because one size doesn't fit all."

Another family carer and carer advocate, highlighting the need for alternative living arrangements to enable people to live in the community for longer, called for alternative thinking in terms of what that home might look like and who we might share it with in our elderhood:

"we have this massive move away from congregated settings for people with disabilities, and yet we still have big residential care centres .... maybe our attachment to our own home could be a barrier to us living independently. And that whole idea of maybe three or four people who have similar values being able to have a property that's adapted .... just in the same way as you have independent living centres or houses for adults with disabilities."[15]

A continuum-of-care approach calls for accompanying community amenities. Thus, in addition to diversified housing stock and living arrangements, focus group participants espoused complementary community-based, open-door, adaptable and intergenerational facilities. The following service manager outlined the value of a community-based and open-door space for people in need of care and their families at the local level:

"You should have that freedom of access, like an open door, like a coffee shop. And certainly, the only place where you can do that is from your own community .... It's something every town needs. .... and it is not necessarily all older people that need care. There are people of varying ages that need care and families that need a day's respite ..."

One example of a network of community-based and open-door venues is the web of 121 Family Resource Centres (FRCs) across Ireland which work to combat disadvantage in communities through "human rights-based, community development and family support programme, operating across the lifecourse" (FRCNF, 2023, p.3). Indeed, the national Age Friendly Programme espouses innovation as one of its values through a commitment to new thinking, methods and approaches. The next chapter focuses on care co-operatives as one such innovative approach and a model of practice for delivering home care.

[15] Independent living is whereby people with a disability are supported to live how and with whom they choose (Hasler, 2003).

5 A Turn to Co-operatives

5.1 Desire for Difference

As reported in Chapter 4, remaining autonomous and independent, and maintaining connections with family, home and community in their old age, emerged as key priorities for study participants.

Depending on their living situation, personal circumstances and health conditions, older people need a range of supports to enable them to enjoy an optimal quality of life. Where there is a deficit in the quantity, quality and range of supports, older people and/or their families may see unnecessary or premature admission to long-term residential care as their only viable option.

The problems inherent in the current care system, including lack of choice or a tiered approach, and variability in the quality and range of care provided, are key concerns for those anticipating future care needs and for family carers who need the support of paid care workers, whether through the public system or private procurement. We also heard from care workers, who experienced poor working terms and conditions in private care companies and highlighted implications for the quality of care provided. This, in turn, exacerbates difficulties in recruiting and retaining care workers at a time when the need for such workers is increasing.

While many of the accounts related by participants reflected the reality of the mounting care crisis, there was also some optimism that a new model of care, specifically, the co-operative model, could meet the needs of care recipients, their family carers and care workers. This chapter sets out to examine, firstly, what is different about the co-operative model that could enable more inclusive design and delivery of care to provide a mutually more rewarding experience for both care recipients and care workers. Secondly, we explore how the care co-operative agenda can be progressed in Ireland by considering how communities or groups of care workers could be supported to develop care co-operatives; and what practical considerations would need to be taken into account by groups interested in starting care co-operatives.

5.2 The Co-operative Difference

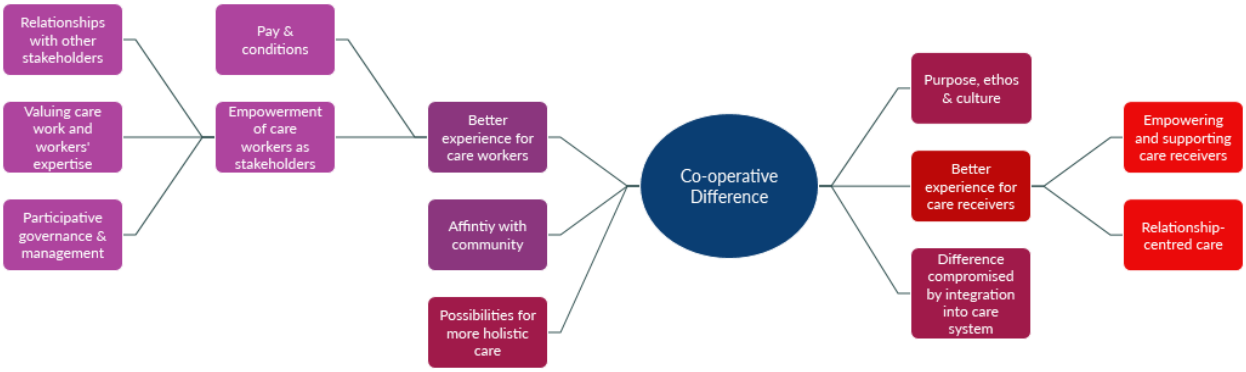
5.2.1 Purpose, Ethos and Culture

The ethos and culture that shape our care system ultimately determine both the quality of care received by individuals and the experience of providing care in a professional or family caregiver capacity. The State's outsourcing of care through tendering processes has been part of the marketisation and commodification of care, which inadvertently favours extractivist business models that prioritise the generation of profit for owners and investors over what should be the core purpose of the organisation – to provide good care. Since the reason for establishing a co-operative is to provide for the mutual needs of members – in the case of a care co-operative, the need for decent work and high-quality service for those needing care – this core purpose, rather than profit, is the primary consideration. Because of their distinctive ethos and culture, co-operatives offer a 'chink of light' to emerge through the growing cracks in the system.

During the focus groups, we explored with participants how the distinctive characteristics of co-operatives could provide a model that would enable the desire for

difference to be realised in communities throughout Ireland. The key themes to emerge from the discussions centred aroundempowerment of care recipients, family carers and care workers, which is made possible through inclusive ownership and the principle of service 'design for use' rather than for profit (Figure 5-1). This creates an ethos that prioritises the collective needs of those using or producing the service.

FIGURE 5-1: THEME OF THE 'CO-OPERATIVE DIFFERENCE' AND ITS TOPICS.



5.2.2 Better Experience for Care Workers

The focus groups of care workers included employees in the public, non-profit and private sectors. While two participants had first-hand experience of working in a care co-operative, the majority had limited knowledge of the model and were curious to learn more. Based on the information shared with participants in webinars, focus groups and supplementary materials, in general the co-operative ethos was viewed by participants as having significant potential to offer a better experience for workers, from meeting the basic needs of decent pay and conditions to higher-order needs that enable workers to enjoy greater job satisfaction and fulfil their professional and personal potential.

Two care workers employed in a co-operative drew on their own experiences of the issues faced by care workers in the for-profit sector to illustrate the appeal of the co-operative model. In both cases, they were attracted by the prospect of better pay and conditions, how their contribution would be valued, and the quality of care delivered.

5.2.2.1 Pay & conditions

A participant from the wider co-operative sector questioned the extent to which co-operatives could address challenges around recruitment and retention:

"Looking at the carer side of it, what would want to be investigated is what's going to make this co-op different to what's there already? [Citing examples of the experience of non-profit care providers] ... they have challenges and a big thing for their carers [is], 'we're doing all this work. Some of us are even better qualified than HSE carers and yet we're on less favourable terms and conditions' ... You talk about the scarcity of the care workers. How would a co-op being set up now ... change that immediately if care assistants or the role of a care worker isn't as lucrative or as interesting for people to be going into that role?"

The experiences of those working in a care co-operative setting suggest that, by offering better pay and conditions and greater job satisfaction, co-operatives could play a

significant role in making care a more attractive career. These workers described pay as being at least on a par with, and sometimes better than, other home care providers:

"We were (up until recently) the best paid and now everybody's come up to match us because it's such a crisis. But we're looking into that ... because we want to pay better than everybody else .... we want our carers to feel appreciated ... We have a pension, there's contributions .... We get [a contribution towards the cost of travel]. We want to make sure that we are a cut above the rest because we want people to see it for what it is and join us."

The co-operative provides guaranteed minimum hours contracts and aims to offer optimal flexibility for workers:

"We make sure that our workers are happy … some people want 30 hours, some people will want 15 .... So, it just depends on the people that we take on, their schedules and what they want."

This co-operative provides more financial stability and security for workers. One care worker, for instance, cited the pension entitlement as a key advantage of their co-operative. In a survey of home care workers in Ireland, O'Neill et al. (2023) found that occupational pension entitlements were rare among care workers employed by either for-profit or non-profit providers. Therefore, in relation to pensions, the GCC is highly progressive.

Comparatively higher remuneration and benefits, and adequate payment of expenses, are made possible by the fact that any surpluses are reinvested in the co-operative, which contrasts with the extractivist profit focus of conventional business models:

"we're above the industry average on everything we do because we don't take the profit back out, we reinvest all the profit back into the social mission."

In terms of working conditions, a key source of frustration for care workers in the for-profit sector is employers' failure, when drawing up schedules, to allow adequate time for travel between clients' homes. Pressurised schedules ultimately impact the quality of care delivered and, consequently, the experience of care receivers. In the GCC, the self-managed teams draw up their own schedules:

"We can actually make sure we have enough time to get from one call to the next, without cutting back on time for any of our clients, so that they actually get their full hour of care ... or whatever length of time their call is, but they get quality time with us."

5.2.2.2 Empowerment of care workers

The governance and operational models adopted by organisations such as the GCC appear more conducive to fostering care workers' self-confidence and professional esteem, enabling greater job satisfaction and personal fulfilment. This is underpinned by an ethos that places a higher value on care work and care workers.

5.2.2.2.1 Valuing care work and workers' expertise

The contribution of care workers tends to be undervalued, not only in terms of remuneration but in the implicit devaluing of the skills and expertise that many care workers bring to the role. Co-operatives that we encountered in this research exemplify

how work practices, organisational models and a particular care ethos empower workers by recognising their insight and knowledge, developed through their experience and their relationships with clients and their families.

CEO of the Equal Care Co-op, Emma Back (2022), explains:

"This fundamental thing is … respect and honour for the role and for the work, because you are changing lives daily as a care and support worker. You are often **the** most important person in that individual's day. And you are the difference between independence and complete dependence. You are the difference between dignity and humiliation. It is a very, very important role."

While workers employed by the HSE generally enjoy better pay and conditions than most counterparts in the for-profit and non-profit sectors, job satisfaction is still impacted by hierarchical organisational structures and related work practices, where care workers have little say in how their clients are managed. One family carer, who described a new HSE system of rotating care workers between different clients (Section 4.4.2.5.1), highlighted the contrast with the experience reported by care co-operative workers:

"I think this aspect of allowing [care workers] to have autonomy, [and] ... respect for their professionalism, for their contribution ... I think the model is really important, and to have carers, the people at home, the family, the community, having a voice in how things are run."

5.2.2.2.2 Encouraging relationships with stakeholders

The HSE rostering practices referred to above, and similar practices reported by workers with experience of for-profit companies, undermine the relationships of mutual respect that are built over time between clients, care workers and family caregivers. By developing close working relationships with each other, care workers in the co-operative enjoy mutual support, which was cited as often being absent in more conventional organisations:

"We've contact with one another; we share phone numbers. I wasn't allowed to do any of that with the previous company ... Everything went through the back office."

"We have a small group of us that end up getting to know each other very well and we give each other a massive amount of support ... there's eight of us [in a local hub], ... one person might have experience the other person hadn't, and we bring it to the team meetings and it's our collective experience, really, the help and the support. I mean, we support each other hugely because we're all in it. We all know how stressful it is and how difficult it can be ... we've come across loads of these issues. So, what we do is, we bring it to the team, we go 'how do we change this?'"

GCC care workers highlighted the importance of carers having a line of communication with each other, and with a range of healthcare professionals involved in a client's care, such as general practitioners (GPs) and public health nurses (PHNs). Some of the key differences were highlighted by care workers:

"We have direct contact with GPs and PHNs ... whereas most other care companies wouldn't allow carers to do that."

"Both [my colleague] and myself have actually advocated for some of our clients for extra care hours ... And the fact that we were able to go back to the PHN and say, 'Look, we have capacity to take that extra hour or half-hour on for that client.' There's never been a problem getting the extra time, ... simplybecause we have said we have capacity to do that."

5.2.2.2.3 Opportunity for participative management and governance

Care workers employed in the co-operative setting explained how participative management models, such as Buurtzorg (see Box 2-1), empower them to create a better experience for both themselves and those receiving care.

"When we work with the co-op, we see all that goes on in the background, whereas if you were just working for another home care provider, the carer wouldn't actually know what work's gone on in the background to get that person discharged."

Workers enjoy supported autonomy, where they are trusted to manage their workloads and their relationships with other stakeholders, with back-office providing a supporting role rather than a top-down role in relation to daily operations.

The job satisfaction that participative management and supported autonomy gives to care workers is likely to be highly significant in attracting and retaining high-calibre staff. One focus group participant with extensive experience in the non-profit sector expressed the view that the co-operative offers:

"a very good model and I think, give it 10 or 12 years, and it may be the dominant model in the sector. For carers, it's that feeling of isolation, lone working, not having a say or a voice in their organisation. If you were to give that to your staff, you would keep them and you would get more staff in, because they would feel ownership of that."

In addition to workers enjoying greater autonomy at an operational level, workers in a care co-operative also have the opportunity to be involved in the overall management and governance of the co-operative, including serving as a director. The researchers heard from participants about the significant positive impact that such participation can have on job satisfaction:

"[Being on the board] means I have a say in everything, right from the very bottom right up to the very top ... There's nothing hidden, everything is up front. We can see what's going on. We can see what's in front of us ... and we know what work has to be done to keep us running ... we are involved in everything."

"It's really interesting to be a part of the business end of things and to learn all the 'ins' and 'outs' of how things do work. And it's great for us then because we can bring back to the [care] team if there's issues or to remind the team in ways that we are still a start-up business and some of the things that might be lacking or that we may need training in and that kind of thing ... it's really important I think to have the care team as a part of the Board and it is actually a part of our Constitution that we're a worker co-operative. So, we do need to have a certain ratio of the care team on the Board. It's fantastic and it gives really good job satisfaction."

The opportunity to participate as a member of the board was a significant boost to morale, as explained by the care co-operative workers:

"[The board responsibilities have] not taken over by any stretch ... but ... it makes a big difference,I suppose, being that valued ... And we do have a say, and what we say and what we contribute is really important because we're on the ground living it, you know?"

"I'm happy to do it because I really want to see this co-op grow. I really, really, really, truly believe that this is the way care should be delivered and received in Ireland. And so, I am more than happyto do that, to make this model grow."

Among focus group participants there was, in general, a positive response to the notion that better working conditions and innovative work organisation and practices such as those adopted by the GCC and Equal Care,empower care workers to deliver a better service for their clients. Together with opportunities for workers to participate in organisational governance, care co-operatives can make care work more attractive and rewarding. This can go some way towards addressing issues of recruitment and retention in the sector while simultaneously enhancing the quality of care provided by workers who are motivated and engaged in their work.

5.2.3 Better Experience for Care Recipients

New and emerging co-operatives, like the GCC and Equal Care Co-op, are socially innovative, not only in terms of their inclusive ownership and organisational structures, but in their approach to care. Guided by their vision of care based on mutual trust and respect, both co-operatives have been proactive in researching and implementing innovative, distinctive work practices and principles. The relationships between the care workers and those receiving care, as well as with healthcare professionals, family and other care supporters, are central to this approach. In the GCC, the careworker-led, Buurtzorg-type, self-managed team model (see Box 2-1) provides greater fulfilment for carers and facilitates better relationships with clients. In the Equal Care Co-op, teams (which may include family, friends, neighbours, and health and social care professionals) are created and led by the person receiving care or a trusted advocate (see Box 2-2). In terms of enabling the delivery of a better quality of care, these innovations are a response to issues such as task-focused care regimes, tightly scheduled calls, and lack of regard for individual preferences, all of which dehumanise care.

5.2.3.1 Empowering and supporting care receivers

The models adopted by the GCC and Equal Care Co-op recognise that care is deeply embedded in relationships. Good working relationships need to be fostered in a meaningful sense to give clients a say in how care is provided and to allow care workers to provide optimal support to their clients. For one care worker, this represented the ideal model:

"I think it comes down to choice. So some people will be very, 'No, I just want you to (especially in the beginning) come and make my breakfast and help me change my bandages and that's all I want',and that can be agreed, that's the whole concept ... the person and then the person's family have ... autonomy to be able to make personal decisions as to how their care package will look ... some people will want more, and some people will want less."

The services provided through conventional 'care packages' were described as often being overly prescriptive and standardised and this may render those receiving care as

passive recipients of a set of care tasks performed by the care workers, undermining the autonomy and agency of the client. Of course, it is acknowledged that those organising and providing care usually have professional expertise, which should not be disregarded, but the wishes of those receiving care also need to be taken into account. This was expressed incisively by a family carer and advocate for change in the care system who highlighted the need:

"to be able to individualise care and not institutionalise care, because what we have at the moment is institutional care."

Despite progress towards a person-centred system in Ireland, a care worker highlighted the pervasiveness of task-focused care schedules and how this contrasts with her experience of working in a co-operative setting:

"It's like, 'this client has to have a shower this time, has to have breakfast at that time, has to have that for breakfast', it's a tick-box exercise. What we [in the care co-operative] do is completely different. We go in, we take each day as it comes ... [the clients] take the lead in how they want their care delivered, which I think is a huge thing. It gives them a say in everything."

A colleague in the co-operative concurred:

"We do make sure that all the boxes are ticked ... Our clients are always fed, they will always be clean, but it will just be in a way that suits them a bit better ... [For instance, if the HSE schedules a call for 9 a.m.] we go to the families and say, 'Look does 9 o'clock suit you? Maybe if it suited you better, we could come at 10?' ... and between us, we'd go back to the HSE and say, '9 o'clock actually doesn't suit either of us. So, is this OK?', and they're going to say yes because if both parties are happy, you know?"

As a result of its inclusive ownership and democratic governance structures, the co-operative model is an excellent fit with the concept of co-production. Co-production involves service providers and recipients working together "in equal and reciprocal partnership, pooling their diverse knowledge and skills. The strengths of people needing support are valued, rather than overlooked, and they have a genuine say in how services work" (Button and Bedford, 2019, p.8).

The advocacy role of care workers in the co-operative is particularly important for clients who do not have family to help to look after their interests. For example, one care worker cited the example of a client who had fewer hours at weekends:

"I think this man had ... only an hour in the evening on a Saturday and Sunday ... we make him a sandwich before we leave, put it in the fridge and he's not eating it. Which means he's going a whole day between morning and night [without eating]. And this particular man, the family wasn't involved at all ... Then the carers were given permission to get in touch with the GP directly. And then on to the nurse, so there was another assessment [for additional home care hours]."

As the co-operative had capacity to provide the additional hours to this client, the hours were granted.

5.2.3.2 Relationship-centred care

While acknowledging some progress by the HSE in their person-centred approach, one advocate for the non-profit sector, highlighted the need for further change towards a relationship-centred approach:

"The HSE needs to change their way of thinking on the model of care. Yes, the person-centred caremodel is great, and it's worked, but [having watched the CO-AGE webinar presentations from representatives of care co-operatives in Ireland and the UK] ... the emergent partnership and relationship care model, that's the way it should be going. I know from my own [experience in a non-profit] company ... We have clients set up and with us for [many] years. That's what you need to bedoing, building relationships with the older person."

One care worker reported her previous experience of having up to 16 different clients in a week, contrasting this with her more recent experience in the care co-operative setting:

"I have the same person half-nine to half-ten, Monday to Friday, and then I have another person then, and each time and each day of the week is allocated to that person. So, I'm always there. They know I'm always there. And if I'm on annual leave we make sure that [it's] somebody that they've either already met ... is involved. So, we notice all the differences in their care. We are in contact directly with their families, with them. They would haveour numbers. So, say I was ill, I'd ring them. I'd say, 'OK. Listen, I'm ill, but I'm working on getting cover'. We would be in direct contact. There's no going back to the back office. So, they know, they trust us, we have really strong relationships."

Mutually respectful relationships are fundamental to Equal Care Co-op's approach, as explained bytheir CEO, Emma Back (2022):

"Person-centred is very customer centric, it's all about individual needs ... but it doesn't look at really the relationship that exists between the person receiving and the person giving … and it always assumes that there is the 'service user' as opposed to this much morereciprocal, mutual aid relationship that involves compromise, it involves consent, and it involves 'give and take'. And each relationship is unique. You cannot just substitute one care worker foranother. It doesn't work."

This approach was attractive to the following family carer:

"I love the idea … that you're looking at it in terms of partners and not providers. I think that's a lovely concept there that this is a collaboration that's a partnership ... that all parties forwhat they're contributing are valued."

From the perspective of an advocate of a rights-based approach to care, the relationship building model adopted by these co-operatives was attractive as it recognises the rights of those involved inproviding and receiving care.

5.2.4 Possibilities for More Holistic Care through Care Co-operatives

The openness of the GCC and Equal Care Co-op to innovative practices at community level is a distinctive feature and suggests that the replication of these models could allow other communities to advance and realise a shared vision of care, underpinned by

individual choice and negotiated relationships between those involved in providing and receiving care.

Community-supported models can enable holistic care that makes it more viable for an older person to live in their own home. Home care tends to have a narrowly defined remit currently, focusing on the basic needs of personal care, such as personal hygiene, feeding, mobility and medical/nursing care (e.g. changing of bandages). Focus group participants, in general, desired a holistic social care model that would provide other supports that an individual might need, such as cleaning and occasional household tasks, to support them to remain in their own home.

In this context, the latent goodwill of neighbours and friends was highlighted. Given the nature of life in modern residential areas, people may not always know what their neighbours might need. For example, as illustrated by one community volunteer:

"I think we all operate in these isolated little pods, and we don't know that the lady up the road is having two people calling in to see her every day, and we don't know that the one thing that really drives her crazy is that she can't put ... the top onto her gas cylinder. Now, there are ... people on my road who would happily do that for her ... but because there's no communication between the [informal] voluntary sector, you know, the neighbour sector and the professional sector, nobody knows that that lady needs the gas cylinder top put on ... And that's a very easy thing [to solve]."

In this example, communication is the missing piece of the jigsaw. This could be remedied by the type of care circles advocated by Equal Care Co-op, where older people could have their needs communicated with trusted neighbours and friends, nominated by them to their care teams.

Part of the holistic care model involves recognising and maintaining the important role of social connections, particularly in the individual's community, in helping them to enjoy optimal wellbeing. In this context, some participants were quite ambitious in terms of what services and supports could be provided through the care co-operative model, extending a holistic approach to supporting older people to live out their old age in the community for as long as possible. One person with experience as a family carer highlighted the importance of social connection and mutual aid, and was attracted to the idea of an organisation "where it's not just a co-op of carers but also of members who are using the care and who get involved". She elaborated:

"If I know one of my neighbours (and I do know my neighbours) [needed some kind of support] ... as a member of this community, I could volunteer hours of care. Not in the sense of responsibility that a paid carer would have, but in the sense of, there's something I can do because I'm able and because I do have some time. So, the sense of co-operative where maybe I could ... have an investment and ... I'm part of that co-op, and once a week, I bring somebody for a cup of tea or something. That's volunteering, I know it's not the same, but the sense of a co-operative where care is a bigger picture and the staff have that level of investment and ownership, but also maybe the care users have as well, and the family."

While this participant wondered if "maybe this is beyond reality", in fact, there are examples of such co-operatives in Japan. In the 'Fureai Kippu' system, volunteers can

earn credits for time spent providing care and support to older members of the community. These credits are registered with their co-operative and can be redeemed when the volunteer needs to purchase support for themselves or their family members (Restakis, 2021, p.187). To some extent, and while recognising challenges such as volunteer willingness, cultural factors, and regulatory compliance, what a community can achieve for the collective good through a co-operative is only limited by their imagination.

5.2.5 Affinity with Communities

Co-operatives are deeply embedded in their communities, and those organising and providing care are better able to relate to the everyday lives of clients because they themselves are part of the community. Their prioritisation of members' needs and concern for community leads to an emphasis on value creation, in contrast to the profit-maximisation priority of conventional businesses (Pencavel, 2013; Dufays et al., 2020). Observing the impact of care commissioning in the UK, Button and Bedford (2019, p.6) highlight the growing dominance of chains of care companies, which results in services "becoming more and more homogenous – defined far from the point of delivery". The impact of this spatial and relational distance between care companies, clients and workers, and the potential of care co-operatives to address these issues, was captured well by one of the focus group participants:

"the private international companies / nursing homes coming in and setting up and not having that community-based ethos ... not having person-based care and not being responsive to the individual needs and preferences of their clients; and also, not having a relationship with the community and not being able to integrate through the community they're set up in. Care affects so many different aspects of a person's life ... you want community connectedness, and you want autonomy, and it seems like co-ops would be conducive to both those things."

Section 4.3.1 discusses features found in communities of place, including social capital or 'community spirit', that help to explain how local embeddedness can be an asset that enables a more holistic care service. A representative of a community-based, non-profit organisation providing care in a rural setting emphasised the significance of local networks in meeting care needs in a rural setting:

"Ours is a ... social enterprise structure. But nonetheless the ethos is the same. It's the bottom-up approach. Because of our long history of working in the area of supporting older people ... the reason the HSE came to us [to establish a local care service] is because the private sector didn't have the contacts on the ground, they didn't know the staff and we have been working with these people ... we're really embedded and connected into community. So, our approach on it was that we actually went to people, people that had worked [with] us [on employment schemes] ... and said, 'you worked on the Meals-on-Wheels service, you worked on XYZ, would you be interested in getting some part-time work if we trained you up?' and that worked really, really well. We've a great relationship with the [local] Education & Training Board here ... and they have been able to deliver the training."

Workers from the GCC spoke of the importance of connection to the wider community and about the GCC's efforts around this, which were impacted by COVID-19:

"We've come up with so many community-based ideas to bring our clients together a little bit, to bring the community together as a whole, the elderly population but ... [the co-op] started in the middle of COVID ... there's actually a load of resources that ... can help people and that are there as a community level and voluntary services."

Among focus group participants, aside from the practical advantages of being connected to community, there was significant positive sentiment towards co-operatives. For instance:

"it's lovely that it's local, that it's in your community, that it's part of where you live and that whatever investment you put into it is going to go on to enrich the community that you live in."

Another individual working in the care sector emphasised the contrast between the approach to care adopted by for-profit providers versus what they considered the superior experience of care provided directly by HSE-employed care workers or, potentially, through co-operatives:

"every town in Ireland should have a Care Co-op ... nobody else is going to advocate for you as well as people in your community. It is the only way to go and wouldn't it be marvellous if ... the HSE woke up and actually realised this is the way to go, instead of going down the road of really encouraging more private companies all the time who are for profit."

Unlike investor-owned care companies, because co-operatives exist to provide a service for local people rather than to generate a profit, they are more resilient and provide greater stability against the threat of service withdrawal and closure. This was highlighted by focus groups participants, for example:

"I mean co-ops in general have been ... very successful; where you're getting banks moving out because they're not profitable, but you're not getting credit unions moving and breaking down because ... again, there's the desire for them to be successful because of the vested interest of the members."

Because they are owned by local people, care co-operatives can also bring wider benefits to the community in terms of higher quality jobs and more vibrant localities, as highlighted by one familycarer:

"when you look at a co-op model where you have people in the community who are working together to create the service, what it does is it contributes back into the community and the fact that people get better pay, get better conditions, that it can be expanded to other people in the community, that the community takes ownership, that shops are kept open, that homes are lived in, all of the issues around derelict Ireland. So, there's so many wider benefits to this other than this one 'look after old people'."

This feature aligns with the idea of more distributed ownership to combat extractivism and build wealth within communities (Kelly, 2012; Raworth, 2017b), as discussed in Chapter 2.

5.2.6 Threat to Co-operative Difference

The foregoing insights and perspectives from the focus group participants highlight broad support for the concept of care co-operatives. Those who had experience of

providing care in a co-operative setting were enthusiastic advocates for the model. For example, one such care worker explained that when she first heard about the co-operative and its approach to care:

"It sounded too good to be true, but we're living it and every single one of our clients are, they're absolutely thrilled. And most of them have had experiences with other care companies. And they're like, 'God, guys, it's chalk and cheese'. It's fantastic and it works, it really is working."

The majority of care workers and related professionals, whose experience ranged from public sector, non-profits, and for-profit care companies, welcomed the idea that carers are valued and rewarded in the co-operative model, and how this could enable greater autonomy for both care workers and care recipients, leading to improved quality of care.

Family carers and those planning for their own old age also generally viewed the model positively, emphasising the links to community and the non-profit ethos as particularly attractive characteristics.

However, while optimism and curiosity about the co-operative model characterised the responses of most focus group participants, there was also some scepticism about the extent to which care co-operatives could drive change within a wider care system that was perceived as fundamentally broken in terms of its economic model and underlying value system. Some of these concerns related to capacity issues, as discussed and, particularly, in relation to competing for business with for-profit care providers and operating according to conditions and work practices laid down by HSE tenders. Furthermore, capacity to comply with the impending new home care regulations will present new challenges for co-operatives and other non-profits.

Even some of the most ardent advocates of the co-operative model acknowledged the constraints imposed on co-operatives by public sector care commissioning. For instance, in her CO-AGE webinar presentation, Aoife Smith (2022), CEO of the GCC, highlighted the challenges of adopting the "more socially-focused, holistic approach" favoured by the co-operative in the context of a public procurement model that is "task-focused":

"This is a huge challenge and it's forcing us to conform to how they actually work."

Veronica Barrett of RHS Home Care, a community-based non-profit provider set up in Roscommon in 1996 as a client/user-owned co-operative society, told us in her public interview:[16]

"we have half-hour calls through the HSE. For our private clients, we don't do half-hour calls, we do hour calls and that gives a bit more flexibility ... the half-hour calls can be a bit challenging alright. At the same time, we structure it so that ... we space out [the calls] ... we can work out a bit of time to spend for the client, which is important."

[16] https://ucc.cloud.panopto.eu/Panopto/Pages/Viewer.aspx?id=466bdef3-35e2-4e0a-a879-af0700b963d4

This illustrates the systemic constraints that co-operatives have to navigate in delivering care according to their own vision.

Co-operatives, in common with other non-profit or independent providers, also face challenges in competing with large for-profit providers for HSE business, who tend to win out in the 'fastest finger first' response to HSE offers of care hours to approved providers.

Related issues, such as recycling of older people's care hours when providers find they do not have the care workers to provide the hours they have accepted, were highlighted in testimonies presented in Section 4.4.2.1. Despite all of these concerns, there was a spirit of optimism and persistence among those trying to change the system through the co-operative model. For example, in terms of work practices:

"We're trying to push the boundaries at the moment. We're trying to convert [the HSE]. Yes, we do have to follow guidelines ... There are certain things that we do have to do. But yeah, we are pushing. ... we're getting there."

One experienced care worker was highly sceptical of the ability of the co-operative to alleviate strain on workers. For instance:

"A co-op ... won't change what support you have at the weekend ... The whole system of the HSE funding, it's broken and until you fix that, you can set up as many co-ops ... I know, I've worked in non-profit organizations, that's not the issue. The [care workers] ... are not the issue ... The issue is the supports are not there."

"HCAs ... They're dealing with leg ulcers, ... dementia ... all of these things on a daily basis because they can't get a public health nurse in whatever area that is. A bank holiday comes up and you quiver because you've got no one till Tuesday."

In the context of these examples, this care worker also raised concerns as to how realistic it would be to improve working conditions through the co-operative model and highlighted the risk that, because care workers are caring, they may put themselves under the same pressures to support their clients beyond the approved care hours:

"You can't leave when someone is dying. You can't say to someone, 'I can't come back to you at lunchtime 'cause the HSE won't give us the money for your hour'. You're going to go back, ..."

From this perspective, the co-operative ethos could not compensate for failures in the system within which they provide services on behalf of the HSE.

In response, workers from the care co-operative were keen to emphasise again their constructive relationships with other healthcare professionals and their ability to advocate for their clients' needs:

"The people ... like the public health nurses, the OT [occupational therapist], they want [to meet clients' needs] just as much as we do. It's ... [the care system] that's causing the problems ... the actual people on the ground [are] ... just as invested in our people as we are, we've found."

Co-operatives also face financial challenges in ensuring that they can provide decent pay for their employees. For instance, the HSE does not pay the provider for care hours not delivered when a client goes into hospital. If a care worker's client goes into long-

term care or dies, it could take several weeks to allocate the care worker to another client, and their income could be reduced by five or six hours every week. According to Aoife Smith (2022) of the GCC:

"The co-op doesn't have the resources to pay people when we lose income ourselves. So, there's that balance between trying to make sure that we're economically and financially sustainable but also creating decent employment."

Despite the best intentions and passionate advocacy of those driving the care co-operative agenda, these concerns must be acknowledged and considered. Through their integration into wider systems, such as commissioned care, where there are significant pressures to conform to standardised practices and bureaucratic structures, co-operatives are vulnerable to a phenomenon known as institutional isomorphism (DiMaggio and Powell, 1983), where over time they lose their distinctiveness and have to adapt to survive in a market over which they have little control. As highlighted by one family carer, who responded positively to the care co-operative model, "while the funding is coming from the HSE, that can create its own power dynamic". This points to the need for health authorities to work in partnership with care co-operatives and other organisations with similar dispositions to advance the agenda to develop a care system that respects clients and care workers.

As implied by the experience of some of the care co-operative workers highlighted above, co-operatives could potentially enjoy an advantage in recruiting and retaining care workers in the context of a shortage of people willing to work in the sector due to poor pay and conditions. This could allow care co-operatives to gain more leverage to influence the creation of a more humanised vision of care.

5.3 From Concept to Reality: Ownership, Structure and Viability

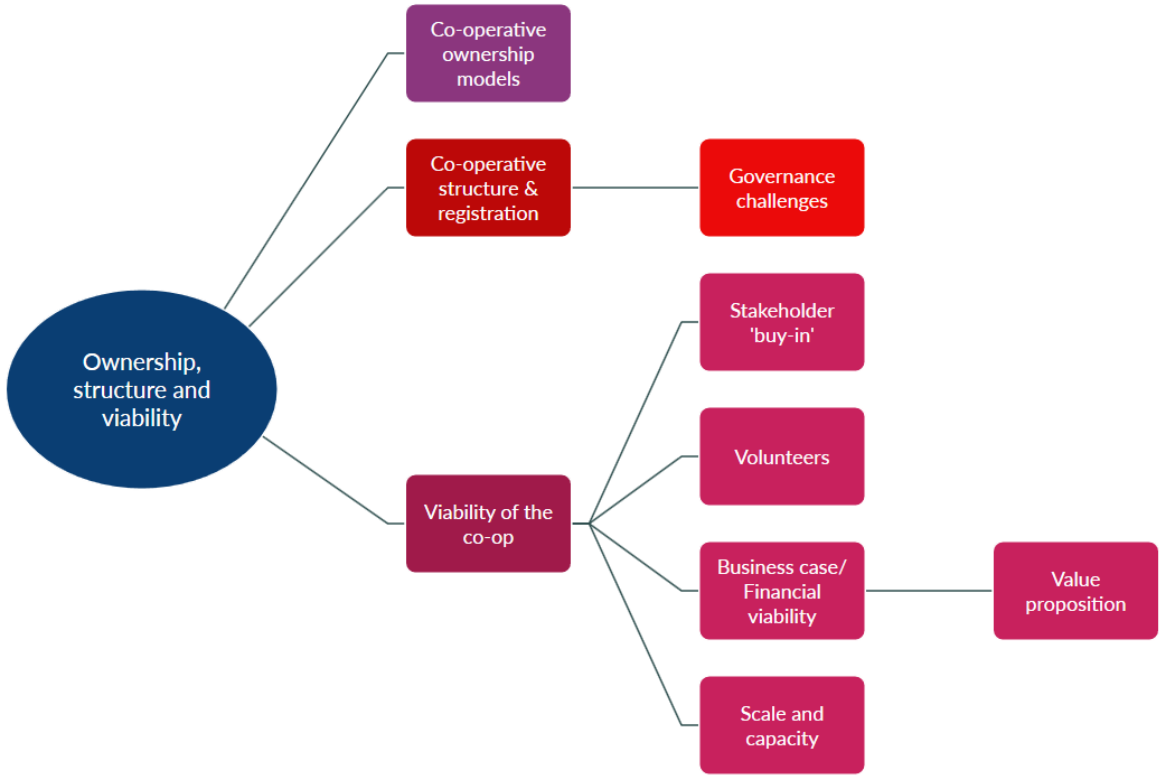
When setting up a care co-operative, there are many practical considerations that need to be worked through to assess the viability of the endeavour and decide on appropriate structures and registration options. This section explores key considerations and challenges identified in consultation with key stakeholders (Figure 5-2).

5.3.1 Optimal Co-operative Ownership Models

In the absence of any policy to stimulate the development of particular types of care co-operative, the ownership model chosen is, to a large extent, determined by the composition of the group of individuals proposing its development. For instance, in the case of the GCC, the initial primary objective was to address the exploitation of migrant workers in the care sector by providing a worker-controlled organisational model. This led naturally to the idea of a worker co-operative.[17] Where a need is identified in a community, then a co-operative owned by members of that community, or a multi-stakeholder model, may be the ultimate ambition.

[17] While the GCC ultimately chose to register as a CLG, it operates according to co-operative principles.

FIGURE 5-2: THEME OF 'OWNERSHIP, STRUCTURE AND VIABILITY' AND ITS TOPICS.



During focus groups, we presented an overview of the worker co-operative and multi-stakeholder co-operative models and asked participants for their views on what might be the most desirable ownership model. In general, there was support for care workers having an ownership stake in the co-operative, ranging from full worker ownership to multi-stakeholder models where workers are included as owners. Although acknowledging that they would need to develop a more thorough understanding of the various co-operative ownership structures, one family carer favoured a worker-owned model because of its potential to empower care workers whose insight and expertise are undervalued in the hierarchical structures that characterise the current care system:

"The bit about the carers having ownership, I think, is really important and one of the points that was mentioned [in the CO-AGE webinar] was around the effort it takes to allow [professional] carers to become de-institutionalised, and to actually have confidence in their ability to say, 'this is what I think'."

Worker ownership was also cited by other participants as offering workers a route to overcome some of the current problems of care work, such as isolation, loneliness and lack of control, with the resulting benefit of attracting and retaining workers in the sector.

Some participants did express a preference for a community-owned or multi-stakeholder model:

"I would like to see very strong representation from workers ... but ... I think it would be better that it was owned by the community, possibly in partnership with the HSE, because the community has an ongoing interest, because it's their grandparents and their parents that are going to be ... part of that co-op, and the community goes on forever."

Despite varying opinions on the most desirable ownership model, there was general agreement among focus group participants that workers should be well represented in the co-operative.

As reported in Section 4.4.2.5.1, we heard from focus group participants about the frustrations of working in a highly rigid system, whereby care schedules and tasks are assigned at back-office level, without consulting care workers. While many care workers would like to do things differently, in ways that could provide a better experience for both care receivers and caregivers, the inflexibility of the existing care system does not allow this, and care workers' opinions are not valued. The choice for care workers would seem to be to either conform or leave the sector. Empowering workers by giving them a stake in the ownership and governance of the co-operative is an important step in enabling organisational and operational models that value care work and care workers.

5.3.2 Significance of Co-operative Structure and Registration

There are many community-based, non-profit, voluntary sector care providers operating in Ireland, some operating under charitable status.[18] Many of these may be classified as community enterprises or social enterprises as they exist to provide a benefit to the community; they generate an income through traded services and reinvest any surpluses in the enterprise. The key difference between a social enterprise and a co-operative is that the latter, once they adhere to co-operative principles, more directly involves stakeholders through ownership and membership of the organisation. Each member of a co-operative is a shareholder and, based on the co-operative principle of 'one-member-one-vote', enjoys equal voting rights with all other members.

In Ireland, organisations that wish to set up formally as co-operatives register with the Registrar of Friendly Societies under the Industrial and Provident Societies Acts (1893-2021). To do this, under current legislation, there is a requirement to have a minimum of seven individuals who have identified a common interest and are willing to form a co-operative.[19] In practice, not all organisations that operate according to co-operative principles actually register as co-operatives, instead choosing to register as a company limited by guarantee (CLG) or as a charity. For example, as previously discussed, the GCC opted to register as a CLG. The fact that groups who want to pursue co-operative processes do not always register as co-operatives has been attributed to several factors, including lack of familiarity or understanding of co-operatives among some professionals involved in supporting enterprise development, and the more cumbersome auditing and reporting requirements currently in place for co-operatives, which can prove expensive and time-consuming.[20] However, one expert advisor to co-operatives

[18] The National Community Care Network represents 23 such non-profit or social enterprise home care providers, https://nccn.ie/, accessed 15/08/2023.

[19] This legislation is currently under review and the Oireachtas Joint Committee on Enterprise, Trade and Employment, in their report on the Co-operative Societies Bill 2022, have recommended that the minimum number of persons be reduced from seven to three.

[20] The Co-operative Societies Bill 2022 proposes a relaxation of these requirements to reduce associated costs and administrative burdens.

emphasised that the advantages of registering as a co-operative from the outset outweigh any perceived obstacles:

"the unfortunate truth about a democratic organisation, whether it be a State or a corporate entity, [is] that democratic oversight by its nature is cumbersome ... But it also has its upsides ... And that's the point that I always emphasise that ... you could get a CLG off the shelf intheory tomorrow, whereas it'll take ... 6, 8, 12 weeks to set up a co-op. But from that day that the co-op is registered, you have a structure that will workfor you and a rule book that's built for the layman or woman to understand ... [Furthermore, in the proposed new legislation] there's a couple of key protections [also] ... that are welcome, in terms of protection of the co-op name ... because obviously it's an attractive brand. People like the vibe of being a co-op and it's very easy topretend you are. And that's something we certainly want to avoid."

Having rules and structures in place designed specifically for the co-operative model facilitate theco-operative to face some of the governance challenges inherent in a democratic business model, as discussed below.

5.3.2.1 Governance challenges

One expert on co-operatives was keen to emphasise the complexity of roles and responsibilities, and the ensuing potential for conflict in the governance of a co-operative. It is important that potential challenges are highlighted to project instigators. For instance, in a worker co-operative, it is important that stakeholders understand:

"that the people who are actually out doing the work will be the ones calling the shots and theywill decide if you are on the board or if you are at the helm."

In particular, they highlight how a manager may oversee and evaluate the work of a care worker atthe operational level but, where care workers are elected to the board, the roles are reversed; as aboard member, the worker may be involved in critiquing the manager's performance and holding them to account. An executive in a care co-operative must have oversight on issues such as quality control and may have to intervene, for instance, in cases of underperformance but, at the board meeting, that executive will have to report to the care workers as board members. This is a scenario that pertains to most co-operatives. It is not an insurmountable problem, but it is important that those interested in setting up a co-operative understand these challenges.

A second and related issue that can emerge as a source of conflict within co-operatives may arise where members have strong, and possibly divergent, views on how the co-operative should operate, and how care should be delivered. This may arise particularly in the case of a multi-stakeholder model, where the care receiver and their family members or other advocates may form strong views on how the service should be delivered:

"Quite rightly they will have a forum to voice [their opinions] ... and it's quite an emotive issue ..."

Because of the potential for conflicts of interest between different stakeholders, the structure and rules of the multi-stakeholder model need particular attention at the very start of the process.

Potential sources of conflict need to be identified at the outset and the structures that are put in place need to be designed with these possible tensions in mind, as explained by a co-operative development executive:

"What I'd look out for when I'm building a rule book or building what the member structure would be like ... [is], 'where's the fight going to be here?' On an issue as important as this ... [the] structures being put in place need a good deal of thought ... A good, expansive and frank discussion at the initial process with whoever is setting it up that, 'this isn't something that you would be anointed the head of and will be untouchable within. It'll be something that will have a very inclusive structure and all the messiness that comes with that and all the difficulty'."

This is not to suggest that the multi-stakeholder model should be avoided. Rather, it is about devising a structure that allows conflict to:

"happen in a constructive manner or be prevented, and that people feel like they've got enough of a say .... You're building a boat and you're anticipating the waves it's going to hit, or the storms it's going to hit, and that it's able to withstand them."

5.3.3 Viability of the Co-operative Enterprise

From the perspective of many stakeholders, a care co-operative, such as the GCC or Equal Care Co-op, seems to provide an ideal organisational model and process that enables the mutual needs of caregivers and receivers to be met through collective action. Focus group participants indicated a clear desire for a more humanised care system and some optimism that co-operatives could deliver this. While this suggests "a gap in the market", as emphasised by one co-operative development executive, we need to ask the question, "is there a market in the gap, or do people want [a co-operative]?" More specifically, can enthusiasm for the idea of a care co-operative among a small group of stakeholders be translated into a viable, sustainable, democratic enterprise? This relies upon several factors.

5.3.3.1 Stakeholder 'buy-in' at start-up phase

As with all co-operatives, the impetus for establishing a care co-operative needs to come from key stakeholders – those who will use or provide the proposed service, and who can mobilise active support that will help sustain the enterprise beyond the initial start-up phase. While there is a role for organisations in raising awareness of the model and facilitating the development of co-operatives, it must be a supported, 'bottom-up' initiative rather than a top-down, imposed solution. Participants involved in supporting community-based initiatives highlight the importance of having a critical mass of people interested and willing to drive the co-operative's development. In particular, they caution against the (albeit well-intentioned) desire of individuals to set up community enterprises based solely on their own vision, or the desire to create a personal legacy, but without the buy-in of the wider community. This was highlighted by an individual with experience of providing finance to community projects:

"the best projects ... [are] born out of real community needs in these local community halls as opposed to just one person ... getting out of bed one morning with this idea in their head. So, when we're looking at every project, we want to see: Where's the idea come from? What's the real level of community buy-in locally? The best projects that

we lend into are the ones where there [are] communities ofhundreds of people behind them."

A lack of community buy-in can become quickly exposed if the organisation gets into financial difficulties, and this becomes highly problematic for the sustainability of the endeavour.

5.3.3.2 Volunteers as drivers of co-operative development

Whether conceived as a co-operative to be owned by workers, by a local community, or multiple stakeholders, a co-operative relies on the willingness, capacity and capability of volunteers to play an active role in its establishment and ongoing governance. The democratic process depends on a voluntary board of directors who are representative of the membership and collectively have the mix of relevant skills and expertise to support a successful co-operative enterprise.

Many people in Ireland are active volunteers in charities and the community. A report by the Charities Regulator (2023) estimates that volunteers contribute work to an estimated value of €1 billion to €2.5 billion to registered charities.[21] Nonetheless, the challenges of recruiting committed volunteers should not be underestimated, particularly in the context of a growing preference for short-term volunteering opportunities and challenges in recruiting younger volunteers.[22]

In the focus groups, we explored whether, hypothetically, people would likely be interested and willing to become actively involved in a care co-operative. We also gained relevant insights from participants who are involved in other community organisations and co-operatives, based on their experience of recruitment and retention of volunteers.

The motivations for becoming actively involved in the governance of a worker co-operative were clearly expressed by care workers in the GCC (Section 5.2.2.2.3). Arguably, the motivation is greater when it offers workers an opportunity to have a say in decisions about the organisation in which they work.

In a community setting, while stakeholders may wish to support the co-operative and use its services where needed, there may not be a commensurate desire to participate in organisational governance or other aspects of volunteering. There was some optimism that members of the community might be willing to volunteer:

"Maybe it wouldn't be difficult to get people to volunteer ... because we're all going to get old. So, I suppose we've got a vested interest in it."

However, participants offered a number of considerations regarding the prospect of their own volunteer involvement in a care co-operative. Reluctance to become

[21] Based on 2022 data, the Charities Regulator estimates that the total wage bill if volunteers were paid the minimum wage would be just under €1 billion, while the cost would increase to €2.5 billion if the average hourly rate was paid.

[22] Volunteer Ireland submission to the CSO on Census 2027, https://www.volunteer.ie/wp-content/uploads/2022/12/Volunteer-Ireland-Submission-to-CSO-on-2027-Census-FINAL.pdf

involved was attributed to a range of issues, including practical considerations and anxiety about accepting responsibility.

One of the key considerations raised was by participants who have parents in older age or other relatives living in different communities to where they themselves live. Even those who were active in their own communities questioned their desire or capacity to become involved in a co-operative outside of their own community. For example, one family carer highlighted the dilemma they would face:

"Even though I've been only living here 15 years, I feel I'm very embedded within my community. So, when I think of my community, I'm thinking of a place, but my parents don't live here. I'm not thinking of myself in terms of care at the moment. I'm still thinking of my parents. You know? So, ... would I be looking at getting involved in something that's in my community, or would it be something that's in my parents' community?"

Another participant expressed some reservations about taking on responsibilities at an advanced age:

"I'd be very worried about taking on that sort of responsibility and organising it because you'd want to give it all ... [Speaking of her previous experience as treasurer on a voluntary fundraising committee] 'twould nearly keep you awake at night. [Trusting others in relation to handling finances of the co-op] would worry me as well, would worry me greatly. The credit union seem to be able to manage it very well because they have a lot of committees, finance people and everything, but starting out a big thing like that is very difficult. You'd want some very well-trained people at it …. I'd do a certain amount, but I'd be worried. I mean, I'm [in my 70s]. When you're [in your 70s], you can't take on that kind of thing anyway, hardly. No."

Considerations were also raised by those with professional experience in the co-operative or voluntary sectors:

"Retaining and recruiting volunteers is getting increasingly difficult .... [Also] you can form a board, but to get the skill set that you want and the people that will bring real value to it, what you'll find is .... it's the busy people that you'll get because they'll have an interest in something or other. It's the people that have lots of time that don't seem to put themselves forward .... So, it's to be aware of what you want on a board and all of that ..."

Echoing this, a co-operative development executive emphasised:

"It can be just getting, not necessarily the number of people, it can be just getting the right people that you can see will coalesce around this organisation and commit to it in the way it needs to be committed to."

The likelihood of being able to attract volunteers with suitable skills and the need to engage in succession planning to ensure the longer-term sustainability of member representation on the board are significant considerations. The GCC model of local hubs operating under one co-operative could be adapted by community or multi-stakeholder co-operatives to ensure local service organisation, delivery and accountability, while limiting the demands on local volunteers. However, in the case of a co-operative upscaling significantly and expanding the geographical reach of its

services, the importance of spatial and relational proximity to members must not be underestimated. Section 5.3.3.4 explores mechanisms through which co-operatives can achieve the benefits of scale while preserving their local affinity.

5.3.3.3 Establishing a financially viable business case for care co-operatives

Co-operatives are 'not for profit' in the sense that they are set up with the primary objective of serving an identified mutual need, rather than to generate profit for owners/shareholders. Since care co-operatives could provide a public service, there is a role for government funding (Section 5.4.4).

However, this does not mean that they should operate as charities or become entirely dependent on government grants and/or philanthropic donations. While these sources of funding may be important during the start-up phase, co-operatives need to become self-sustaining and financially viable. Some co-operatives may have to service loan repayments and interest for start-up and development capital. This was highlighted by a representative of an organisation involved in the provision of loans to community projects:

"If an organisation ... can justify their repayment capacity, but there's another privately-owned care support network somewhere locally, you have to ask the question[s]: ... Why do you need this community-owned facility? What's the difference? What's your unique selling point? What benefits are you bringing to the marketplace that the existing provider can't?"

Ultimately, co-operatives could be a driving force in the transition from a capitalocentric care system to one that is more relationship-centred and more appropriately values and rewards care work. Meanwhile, they have to balance the co-operative ideal with the economic realities of operating within the current care system. In this context, it is essential that a co-operative develops a viable business plan, based on a clearly articulated value proposition, that will enable it to generate sufficient revenue to cover costs and, over time, generate surpluses, which can be used to build up financial reserves, and reinvest in the development of the enterprise or other initiatives agreed by the membership.

5.3.3.3.1 The value proposition

The identification and articulation of a clear value proposition is critical to the development of a business model. The value proposition should reflect the co-operative's social and economic objectives and should offer particular benefits to members that cannot be obtained outside of the co-operative (Mazzarol, 2015). For those with care needs and their families, the expectation would be the provision of a service that is in some way superior, such as through inclusive design and the ability to negotiate how care is delivered. If there is a decline in the quality of service provided by a co-operative, support and patronage of the co-operative may wain (Lorenzi et al., 2016). A co-operative will be self-sustaining only if it is used by those requiring care services and, within the current care system in Ireland, can compete successfully for public procurement contracts and establish itself as a preferred choice for those paying for private care. To do this, it must be able to guarantee excellent care. As voiced by one co-operative advocate:

"We can't just say that co-ops are inherently better ... the first step of that is actually operationally being really good at what you do because you can't use the co-op difference to make up for a deficiency in providing a service."

This was echoed by another participant from the wider co-operative sector who raised the question:

"What's going to make this co-op different ... there needs to be something out of it for the members ... Can we guarantee great care? But we don't want that at the expense of the care workers or the families depending on the service. There just seems to be so many challenges in this area ... it just seems to be that caring isn't as attractive or favourable to people as it once was. And the question is, why is that the case and how is our care co-op ... going to be any different from what's there already? ... Caring is particularly special because other people are vulnerable, and they need this. So, it's just to be aware of what's going to be different [about a co-op]."

This contributor's point about challenges in terms of recruitment and retention of care workers points to the need for the value proposition of the co-operative from a care worker's perspective to be clearly articulated and communicated. In this context, the value proposition is likely to be based on more democratic structures and processes, better pay and conditions, and greater job satisfaction. If a co-operative is unable to deliver on these objectives, or if these advantages become eroded over time, the co-operative will face recruitment and retention challenges similar to those experienced by other care providers currently.

The value proposition is a key component of the business case that differentiates care co-operatives from their competitors. However, while this may help to secure business from private clients, under the current system of care commissioning, co-operatives have to face the reality of price-based competition with large for-profit providers. In a rural area, the case for a care co-operative may be clearer if there is a dearth of care services locally. This may happen as a result of private companies avoiding rural areas due to higher costs and lower profit margins:

"If you're living outside of a main population area ... and if [care workers] are not getting paid or they're not adequately remunerated for their travel expenses ... it makes sense that you would look at a community and see is there scope to set up a co-operative within a community setting where you've got a defined geographical area, but then it also partners with other co-operatives in adjacent or other areas."

Securing business may involve significant efforts directed towards awareness raising and communication with stakeholders about the co-operative care model. Stakeholders include people in local communities, care workers, and those with responsibility for public procurement of care services. Furthermore, it is essential that public sector organisations charged with responsibility for care services are enabled by regulation and policy to actively support co-operatives through partnership and the procurement of care services and, where appropriate, to provide them with the level of certainty and consistency of funding required to enable long-term planning.

5.3.3.4 Scale, capacity and collaboration

One particular aspect of the care co-operative model that appealed to focus group participants was the small scale and local embeddedness of these organisations, which are designed to meet the care needs of particular communities. This was contrasted with the profit-oriented extractivism of large-scale, often multinational chains of care companies. The co-operative model also offers efficiencies in relation to reduced travel time between clients and lower travel costs. While the GCC has expanded from its original core into two additional communities, it is still organised into local operational hubs:

"Our aim is to set up more hubs ... we're never gonna have to travel 40 minutes here or there. Some of my clients are five minutes', two-minutes' drive between each other. And then we'd hopefully set up [new hubs] and expand out ... until we have hubs everywhere. So, it's the hubs themselves that will be taking on [the work] ... they'll be able to take on packages for people in that area .... if you have enough carers, you can take on enough packages."

This structure offers distinct advantages in terms of relational assets and efficiencies. However, small scale can also be a potential drawback in terms of capacity to deliver services. The principle of co-operation among co-operatives, as discussed below, offers possibilities to address the limits of small scale but is more difficult to operationlise at the nascent stage of co-operative development when there are few or no nearby care co-operatives.

GCC representatives were keen to stress their flexible approach to ensure that, where possible, capacity can be met but they conceded that there could be some capacity constraints, for example, where co-operatives are asked to take on clients at short notice due to discharge from hospital:

"We make sure that we won't accept a [care] package if we're not absolutely sure we can give the best care. So, unfortunately, we have to turn down [some business]. It's really difficult .... But if we don't have capacity to be sure that we have the best care for them, we can't take it on, unfortunately."

This is in marked contrast with private providers who, in the experience of some focus groups participants, will accept offers of work but then may find that they also do not have capacity to provide the service, as described in Section 4.4.2.1. For one experienced care worker, these possible capacity constraints raised concerns that:

"co-ops are going to have to be like a niche market .... [e.g. clients] cherry picked for what suits the care workers that you have available."

However, care co-operative workers were keen to emphasise that they have the operational expertise required to meet the care needs of clients ranging from low dependency to those with more advanced care needs, including palliative care:

"We're all qualified healthcare assistants and ... we want people with a minimum of two-years' experience and the eight modules [referring to units of learning in QQI Level 5 courses for home support assistants]; two modules absolutely crucial, and being willing to work up to getting the full eight modules. So, we're all completely qualified and have

experience. We're all qualified to take on much heavier [care] packages or much more dependency."

"We've never come across anything that we're not able to provide because … say, it's something that would need a nurse to come in maybe once a week ... The public health nurses are able and willing to do that."

According to HSE tendering requirements, intending care providers must demonstrate their capacity to deliver services across a particular geographical area.[23] While small, local scale is a key component of the care co-operative value proposition, it could, potentially, have a negative impact on financial viability because capacity constraints may become an impediment to competing for and accepting new business. Employing an adequate number of care workers to meet demand, in tandem with the focus on providing them with a decent income and working conditions, does present a predicament for care co-operatives. While a for-profit company may not have an issue with keeping staff on their books and not paying them when there is no work, this would go against a co-operative's aim of providing a consistent income for care workers. Therefore, as described by a GCC worker, co-operatives may face "a catch-22 situation", where they need to have carers available to enable the co-operative to take on home care packages but if there are delays in the commencement of care packages, workers who have signed up may seek employment elsewhere.

An additional challenge for small, local, co-operatives relates to clinical governance requirements, which require home care providers to have access to clinical expertise under the impending home care regulations[24]. A participant with extensive experience in the non-profit care sector suggested:

"Co-ops will face a huge difficulty ... under the terms of the current service level agreements and the tender, there has to be clinical leads in place, such as a nurse on staff. There has to be oversight ... it's going to be even stricter than it was previously. So, the funding they're going to need is going to increase because they will need to have all that structure in place before they go for tender, because they will not pass the tender process and they will not be able to take new business."

Collaborative arrangements and structures can go some way towards addressing these, and other, scale-related challenges. Under the current HSE tendering arrangements, there is an option for care providers to partner with other organisations and tender as a consortium in order to meet 'quantum of service' requirements. The sixth co-operative principle, *co-operation among co-operatives,* encourages co-operatives to work together for mutual benefit and the benefit of the wider movement. If there were several care co-operatives within a given health area, co-operation would enable them to strengthen capacity to service contracts that would be too large for any individual co-operative. With regard to clinical governance, co-operatives can operate in local

[23] At the time of correspondence with the HSE (May 2023), there were nine Community Health Organisation (CHO) areas under which home care and other community-based services were organised. As part of a spatial reconfiguration of territorial divisions in the HSE, the nine CHO areas and six hospital group areas are being replaced by six new Health Regions in 2024.

[24] Draft Regulations for Providers of Home Support Services – Public Consultation Document, June 2022.

hubs (similar to the GCC model) while being constituents of a larger co-operative, thereby achieving the scale required to employ clinical governance leads. There is also scope for co-operation with other care co-operatives, or with other non-profits, such as through the National Community Care Network, which is currently developing policy and governance supports and auditing tools for members. The need for ongoing professional development is another area which could be addressed through collaborative structures.

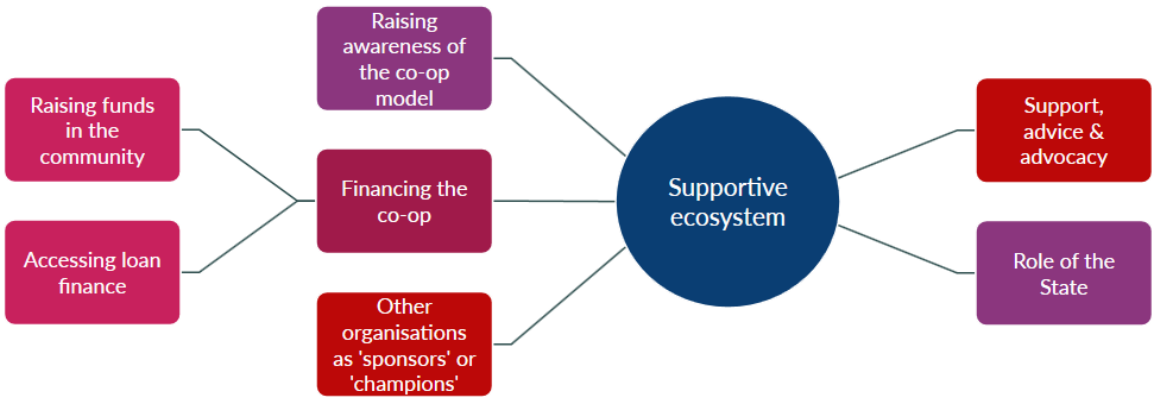
Additionally, co-operatives can develop shared services through collaborative structures such as secondary co-operatives or federated models, a pathway that could also address some of the challenges of scale, provide for pooling of resources and expertise, and development of shared IT systems and infrastructure. This is a practice already used to good effect by credit unions. As expressed by one participant, this would:

"reduce costs and enhance interconnection between co-ops ... It's just so much easier to do that as one thing and everyone pays for it. It's the same system. If a carer moves from [one co-op to another], they can pick up the same system."

5.4 Developing a Supportive Ecosystem for Care Co-operatives

If care co-operatives are to form part of the solution to Ireland's care sector challenges, there needs to be a supportive ecosystem to foster their propagation and development. This section considers some of the key components of this ecosystem. These include awareness raising of the co-operative model among stakeholders; supportive policy, regulation and legislation; access to finance, including government-funded stimulus programmes; and dedicated co-operative advisory services (Figure 5-3). We also explore what existing financial resources and expertise might be available that could be leveraged by groups wishing to set up care co-operatives.

FIGURE 5-3: THEME OF 'SUPPORTIVE ECOSYSTEM' AND ITS TOPICS.



5.4.1 Raising Awareness of the Co-operative Model

The first step towards encouraging the development of care co-operatives is to generate awareness and understanding among stakeholder groups. A representative from an age advocacy organisation observed that the co-operative model would seem to reflect key characteristics of a desirable care model and that people would likely respond well to the idea if there was more awareness:

"I don't know that we've ever gotten a call [from someone saying] 'God, I wish there was a care co-op' ... But I think if people knew what co-ops were or if they were on board with that, that would bean easy enough sell for a lot of people."

Herein lies a key challenge. Lack of awareness and understanding of the co-operative model represents a significant constraint to stimulating the expansion of Ireland's embryonic co-operative home care sector.

In theory, due to their ethos and principles as already outlined, co-operatives should enjoy competitive advantage deriving from what is termed the 'co-operative difference', which supports their value proposition both in terms of competing for business or recruiting staff. However, communicating and capitalising on this difference is a challenge faced by many co-operatives.

From the perspective of care workers already experiencing the worker co-operative model, once care workers are introduced to the concept of a care co-operative, many respond very positively to the way care work is organised. However, as highlighted by one of the focus group participants, it can be difficult to stimulate workers' interest inthe model, simply because:

"It's hard to actually reach out to the carers and tell them how we're doing things differently."

This suggests a need to work with organisations, such as trade unions, to raise awareness amongcare workers of the co-operative difference and the opportunities it presents. Other potential targets for awareness-raising include development organisations that work at local level to animate and facilitate community groups to develop bottom-up solutions to local service gaps.

In the case of the GCC, the Migrant Rights Centre Ireland (MRCI) was well-positioned to communicate with migrant care workers through its core advisory and advocacy roles. Effectively acting as a 'sponsor organisation', the MRCI was able to facilitate the co-operative's development and drive momentum. Sponsor organisations can certainly play a valuable role in the sector's development. However, since care co-operatives cannot be imposed and must be started voluntarily as 'bottom-up' initiatives, usually by communities or care workers, reaching out to stakeholders and communicating about the model is a prerequisite for any development to take place.

Focus group participants from within and outside the credit union sector highlighted the credibility of credit unions in Ireland as trusted organisations and potential communicators of the co-operative difference. Credit unions have consistently won awards for being the most reputable and trusted organisation in Ireland and delivering the best customer experiences.[25] In this context, a professional from a local and

[25] Credit Unions ranked as Number One in 2023 Reptrak® study. 10 May 2023. https://www.creditunion.ie/news/latest-news/credit-unions-ranked-as-number-one-in-2023-reptrak/?fbclid=IwAR28raZbd7dA9EMzWq_JhsCJ09NPDAZ3htDspnvgIsWxttNRDgI7OzFe7B4

Credit Unions named champions for Customer Experience for unprecedented 9th consecutive year. 3 October 2023. https://www.creditunion.ie/news/latest-news/credit-unions-named-champions-for-customer-experie/

community development organisation emphasised the potential role of credit unions in helping to promote awareness of the co-operative model:

"The likes of [our local] credit union are so embedded in the community for 40/50 years and there'sgreat respect. We all know the charity sector has been hit by a lot of scandal ... I think that the credit union model would be fantastic because you're so nationally recognised and the respect is there."

A participant from the credit union sector agreed:

"credit unions are almost in every village and town across the island of Ireland, so they're a natural fit for any type of outreach like this ... this type of stuff lies at the heart of credit unions and what they do."

5.4.2 Support, Advice and Advocacy for Co-operatives

Where groups of stakeholders become interested in setting up a co-operative, there must be accessible knowledge and advisory services to support them. Currently, the Irish Co-operative Organisation Society (ICOS) is the main representative and advisory body providing supports to co-operatives across a range of sectors. In the 1990s, there was a State-funded Co-operative Development Unit (CDU), which was disbanded in 2002. The Oireachtas Joint Committee on Enterprise, Trade and Employment has recommended the re-establishment of the CDU under impending legislation to provide advice, training and support to co-operatives and has also recommended that Local Enterprise Offices' capacity to support co-operative development be strengthened.[26]

The need for development of co-ordinated support mechanisms was identified by focus group participants as critical to enabling groups to pursue the co-operative care model. While recognising the role of ICOS as an advisory body for co-operatives, the need for a dedicated organisation for the development of co-operatives *in the field of care,* in particular, was identified:

"It's not their [ICOS] job to be a subject matter expert in terms of care, so that's great that it exists, but it's about this as a Caring Ireland. I think that expertise needs to be developed and structured."

This participant felt strongly that, to avoid a fragmented model where different communities experiment with different versions of co-operatives, a co-ordinated approach would be required:

"I really think that there needs to be an umbrella, whether you call it the Co-op Advisory or whatever it is, who can provide all of that information, can provide lessons learnt, can provide templates [for consideration by] a group of volunteers .... I think it's such a waste of time and effort for volunteers to sit there and re-examine and re-explore things that somebody else is doing [elsewhere] ... to have a group of people who are willing to support all of the individual groups, to provide the information, to take feedback, all of

[26] Oireachtas Joint Committee on Enterprise Trade and Employment. Report on the Pre-Legislative Scrutiny of the General Scheme of the Co-operative Societies Bill, 2022. April 2023. https://data.oireachtas.ie/ie/oireachtas/committee/dail/33/joint_committee_on_enterprise_trade_and_employment/reports/2023/2023-05-03_report-on-the-pre-legislative-scrutiny-of-the-general-scheme-of-the-co-operative-societies-bill-2022_en.pdf

that. Otherwise, we're just all doing it by the seat of our pants, and it takes much longer, and we lose lessons learnt, and we're reinventing wheels that don't need to be reinvented."

There is also a need for **education and training** for those interested in taking on active roles in a proposed co-operative. Education both supports and

"empowers those people to know what the responsibilities are alongside the work they're doing, and give them the confidence to say, 'listen, you're a carer [care worker], 9 to 5 or longer than 9 to 5, and you can be a co-op director and a leader of a business and a leader of your peers, at your board meeting or in your members' meetings'."

Participants also saw a role for a co-ordinating body in fostering solidarity among co-operatives, collectively representing them and advancing the co-operative agenda, including liaising with the Department of Health and the HSE, and advocating for policy change. If a co-ordinating body were to take on an advocacy and representative role, then it would need to be independent of the State. A federation of co-operatives or a representative body, similar to the Irish League of Credit Unions, for example, could be the optimal way to achieve this.

5.4.3 Financing the Co-operative

Access to finance for start-up costs, development and expansion represents a significant challenge for groups aspiring to set up a co-operative. Reflecting on her experience in RHS Home Care, Veronica Barrett[27] highlights the importance of start-up finance:

"It's very hard to start, to be working without proper resources, and I'm talking about money ... Everybody was on board as regards, 'yes, this is a good idea' but an idea is not enough to make a success of something, you have to have money as well, unfortunately. So, that was the biggest challenge over the years."

The importance of access to funding for business development was also highlighted by the CEO of the GCC (Smith, 2022):

"Until we start scaling more hubs, we need to get investment for the business development team to set up the technology, the software, the HR and all of that to run it."

Various social economy funding sources – EU, government and philanthropic – can offer resources to enable groundwork, such as training and development. The GCC, for instance, has benefitted from the European Social Fund and also funding from Rethink Ireland, a social innovation support organisation funded by government and philanthropic donations.

Several participants emphasised the need for an obligation on the State to use the services of care co-operatives and to provide adequate funding. This would include a funding stream from the Department of Health or the HSE to assist with the set-up and development of care co-operatives. The Dormant Accounts Fund, which uses

[27] Interview with Veronica Barrett available at https://www.ucc.ie/en/iss21/researchprojects/researchprojects/earlieriss21projects/co-age/.

unclaimed funds in banking institutions to support initiatives that tackle economic and social disadvantage or support those with a disability, was identified as one possible source of funding to help start-up care co-operatives.

Based on the experience of voluntary organisations funded under Section 39 of the Health Act (2004), focus group participants cautioned that sustainable and adequate funding was necessary for care co-operatives to flourish:

"many of them are still getting the same funding that they would have got 10 years ago ... there could be a lot of money thrown at something at the very start. But ... [unless there are] incrementalincreases ... in line with inflation ... as time goes on, the resourcing just isn't there."

The issue of State funding and patronage is fundamentally linked to policy, which is explored further in Section 5.4.4.

5.4.3.1 Raising funds within the community

Where a community agrees on the need for a care co-operative, it would make sense that those whohave the means to invest in the co-operative would be enabled to do so. We heard from Emma Back of Equal Care Co-op in the UK about how they have used community share offerings to attract investment from those who wish to support the co-operative. Community share offerings allow individuals to invest their money by buying shares in a co-operative. Such offerings do not attract speculative investors motivated by financial gain; in some cases, there may be a modest return on investment but, while shares can be withdrawn, they are non-transferable and, therefore, cannot be sold outside the co-operative. Co-operative Alternatives, the main co-operative advisory body in Northern Ireland, cite community share offerings as critical to meeting the capital requirements of co-operatives when starting up or scaling up.[28]

Currently, co-operatives in the Republic of Ireland are prohibited from raising funds through such share offerings. The Co-operative Societies Bill 2022 signals the intention to remove this restriction. However, special provisions would need to be put in place to facilitate co-operatives to raise funds through community share offerings. For example, provision for an asset lock, which safeguards the assets of a co-operative for collective benefit and protects against their use for individual gain, would be important in building prospective investors' confidence in the model.

In the absence of a formal community share offering, communities will sometimes try to raise finance through donations from the local community. However, a co-operative development executive cautions against over-optimism:

"A lot of people come to me and they say, 'we'll get €500 per household or €1,000 per household' and my blunt response is 'you probably won't'."

Even when there is general support for an idea, individuals and households may not have the financial means to make such contributions, and those who do have the means need to be convinced of the ability of the instigators to make the initiative work.

[28] Report of the Pre-legislative Scrutiny of the General Scheme of the Co-operative Societies Bill 2022

5.4.3.2 Accessing loan finance

It is likely that a start-up co-operative would need to obtain loan finance to develop the enterprise. In the experience of a co-operative development executive:

"Getting funding can be difficult ... [when] you're just a group of people who've set up a corporate entity. Who are you? What's your repayment track record? ... Some of the time ... I would say 'yes, this is a co-op that we need, this is something that I'd like to see on the scene [but] ... do I see this still being in operation in three to five years' time?'"

Relating back to the earlier discussion of the need for a strong business case, a participant withexpertise in providing loans to community projects emphasised:

"Everything that we lend to has to be able to show us how they're going to have the ability to make repayments plus interest on the bottom line going forward."

International research highlights how credit unions and co-operative banks can be a significant source of loan finance for social co-operatives. Conaty (2014), for instance, highlights the role of Quebec's credit union movement, Caisses Desjardins, in providing social finance to solidarity co-operatives, especially in the health and care sectors, and also how social co-operatives in Italy have sourced loan finance through co-operative banks.

Several senior credit union representatives participated in the focus groups, which in itself is indicative of positive sentiment towards the idea of care co-operatives, and a healthy indication of the spirit of co-operation among co-operatives. In general, these individuals were keen that credit unions would play their part in supporting care co-operative development. Commenting on a recent loan to a co-operative in their credit union's locality, one CEO reflected:

"Obviously we assessed the risk ... [including] capacity to repay. But ... we viewed it as being kind of something that tied up with our own social ethos ... that they were a co-operative. It really tied in nicely with what we wanted to do as an organisation .... to see can credit unions really step into that space nationally where effectively co-operative money is being retained within co-operatives and being recirculated in the co-operatives, and they don't need to go out to the banking environment to avail of funds ... Can we utilize an element of [our assets] more constructively for those who are living within our immediate locality? And can we leverage off that to support better community organisations, better community initiatives?"

A collaborative approach between credit unions and other stakeholders was supported by participating credit union CEOs:

"Probably it'll be harder for individual credit unions to be going into something like this, whereas if itwas set up something like a [collaborative initiative within the credit union sector where] ... the government would be involved as well ..."

Potential obstacles to providing finance to care co-operatives include the need for regulatorycompliance and Central Bank approval:

"We'd have the best will in the world but it's to get the backing and to be able to do it legally is thechallenge. But that's not saying it's insurmountable, it's just that it needs

investigation, and ... a clear plan of action as to what [a care co-operative] will look like at the end before you try to go securing funding for it."

Notwithstanding regulatory constraints and some understandable reservations about the potential reputational risk to credit unions arising if care co-operatives failed to deliver a high-quality service, there was significant goodwill in terms of working collaboratively to support the sector.

The enthusiasm within the credit union movement for using assets to provide loans to community projects is evident in the launch in 2023 of a co-lending scheme by the Irish League of Credit Unions and Community Finance Ireland. This collaboration allows credit unions to provide larger loans to community organisations without over-exposing individual credit unions to risk.

5.4.4 The Role of the State

Ireland's current home care model is characterised by increased outsourcing of care and a growing role and market share for large, for-profit care companies. Procurement of care services from large private companies may appear to offer advantages for the HSE in terms of costs and efficiencies. However, this is not a sustainable model, particularly given the recruitment and retention challenges arising from poor pay and conditions in a system where care work is not appropriately valued. These and other problems associated with the current trajectory of the care system point to the need for a pivot to a system that values and rewards care; one that demands that the State and its institutions work in greater partnership with interested stakeholders, such as civil society organisations and communities, to plan, design and resource the care system envisioned in this study.

There was concern among some participants, including those who were well disposed to the development of care co-operatives, that, in taking responsibility for care, co-operatives might absolve the State of its responsibility to provide care services, while perpetuating the current ad hoc provision of services:

"all of these charitable concerns that we use in Ireland to provide services so that the government outsources its responsibility for things like cancer support or children with special needs or mental health services – the problem is, it becomes really sporadic around the country and you're gonna be lucky about where you live, whether that service is available."

The need for a meaningful and sustained financial commitment to care co-operatives by the State was expressed very emphatically by one family carer:

"I think there needs to be just government commitment with regards to funding and acknowledging that they don't know the right way to do things, and that as communities we are willing to stand up and make that happen ... they then have corresponding responsibility to (a) use co-ops before they use the private organisations, 'cause really you just want those to be gotten rid of. And [(b)] that they commit to ... proper funding and support without then demanding ownership."

Within the current care system, most people in Ireland who avail of care rely primarily on HSE-funded services. If co-operatives are not able to compete successfully for HSE contracts, they will be dependent on private clients, which is unlikely to result in viable

enterprises. The view that private providers should be eradicated represents a particularly strong ideological standpoint, aligned with views of some other participants who opposed the capitalist, extractive model of care. While there is a strong case for appropriate government support for co-operatives and non-profit providers, a complete supplanting of for-profit home care providers by co-operatives is not viable in the shorter term. It would require considerable political will and radical reform, both of which would take time. It would also involve a range of complex considerations related to service continuity and public procurement. Since co-operatives must be bottom-up initiatives where those who use or provide care enter into a co-operative voluntarily, they cannot be an imposed solution. It would take some time to grow scale and capacity in a nascent care co-operative sector; in the meantime, an impending radical shift away from marketisation might lead to private providers rapidly exiting the market, leaving service gaps before co-operatives could be scaled to meet demand. Furthermore, private home care providers are collectively a significant lobby group and are likely to challenge the legality of any preferential treatment or subsidies paid to co-operatives and other non-profits.

If a version of the existing care commissioning system is to be maintained, at least in the medium term, a key enabler of preferential treatment of care co-operatives and other non-profits would be the introduction of legislation to allow social value criteria to be a key determinant when awarding public service contracts. However, a more ambitious agenda would revisit how home care is organised.

A key component of the reform agenda would be the allocation of personal budgets to those who need to avail of care and support. Personal budgets are consistent with a rights-based approach to care, empowering care recipients to choose the type of supports they need and choose who provides that support. The HSE introduced Consumer Directed Home Support (CDHS) to provide "more choice and autonomy for clients wishing to have more control of their home support service" (correspondence with HSE, June 2023). Care recipients who are deemed eligible for this scheme may choose from a list of HSE-approved providers and organise their own care. The HSE was not able to provide data on the numbers availing of the CDHS scheme but reported that uptake has been low (correspondence with HSE, June 2023). Although the HSE confirmed that the CDHS is available nationally, anecdotal evidence suggests it is not available in all counties.

Personal budgets would certainly provide more autonomy to care recipients, and they would also create opportunities for care co-operatives to prove themselves in terms of quality of service and become providers of choice to personal budget holders. This could allow co-operatives to grow their capacity and become self-sustaining. However, it must be acknowledged that there are also potential disadvantages associated with personal budgets, particularly where, in the context of a shortage of care workers, individuals may struggle to secure care services. This would have a disproportionate impact on people in rural areas, where private care companies may be less likely to supply care workers due to time and costs associated with travel to more remotely located clients. Therefore, personal budgets offer a solution for some clients **who choose** to manage their own care budgets but a full transition to such a scheme would further discharge the State of its responsibility to provide care, particularly for many older

people and their families for whom the procurement and organisation of care could become an additional burden.

5.4.4.1 A role for co-operatives in influencing care system reform

The International Organisation of Industrial and Service Co-operatives argues that: "It is in everyone's interest – communities, workers, and public authorities - to go beyond a 'subcontracting approach' and to involve cooperatives in the co-design of the care programs, since they are the expression of the community needs" (CICOPA, 2023, p.26). While a full transition away from subcontracting seems unlikely in the Irish system, much of the language used in documents outlining Government's Sláintecare healthcare reform programme suggests a significant opportunity for organisations such as co-operatives to play a role in shaping the care system. One such example is the implementation plan for the geographical reorganisation of the HSE, which involves the replacement of nine Community Health Organisations and six Hospital Groups with six HSE Health Regions in 2024 "to facilitate the delivery of integrated health and social care designed around people and planned around communities" (Government of Ireland, 2023b, p.10). Included in the nine service design principles outlined in this implementation plan are collaborative design, "to ensure the voices of all interested stakeholders are considered, with early and ongoing engagement and a collaborative approach to seeking input on national and local services" (p.11) and an approach to design that ensures that the Irish health and social care system is "an attractive place to work, and allows staff to maximise their potential and productivity, as well as providing opportunities for career progression and skills development" (p.11). The design approach provides for "clear interfaces, partnerships, and aligned incentives" (p.11) with a range of stakeholders, including Section 39 organisations and private providers. This suggests a strong alignment of strategy with Eisler's idea of partnerism. Co-operatives could provide a structure to enable this collaborative approach, where the lived experiences of care workers and those receiving care are embedded in the design of integrated care.

The innovative and collaborative 'partnership-style' relationships between the voluntary and statutory sectors, which emerged as a fundamental component of the national response to the COVID-19 emergency, highlighted how mutually dependent organisations can work together for the public good (Thomas, 2021). The Health Dialogue Forum (2023) emphasises how "the voluntary sector's organic rootedness in the community enabled it to respond in a quick and innovative manner and there is a sense that this particular 'quality' is now more explicitly recognised and appreciated by the State" (p.21). As already discussed in Section 4.1.3, "this particular quality" is in fact the manifestation of social capital in a local area and, by extension, a community's capacity for self-help.

The Health Dialogue Forum also highlights the relevance of Government's five-year strategy to support the community and voluntary sector. The strategy proclaims that: "Community resilience will be strengthened, with communities supported to identify their own needs and develop actions based on these needs, and empowered to take ownership of initiatives that strengthen their capacity to meet emerging challenges" (Government of Ireland, 2019, p.19). As democratic organisations, owned by communities of place or practice, and which design services based on what is in the

mutually agreed interests of service users and workers, care co-operatives are an excellent fit for this element of Government's strategy.

It has been acknowledged that there is a "problematic relationship" between the voluntary and statutory sectors in health and social care (Independent Review Group, 2019; Thomas, 2021). Specifically, while voluntary organisations are independent entities, increased regulation and accountability have led to a "command and control type relationship" between the State and the voluntary sector (Health Dialogue Forum, 2023, p.7). This is a key consideration for co-operatives, given their responsibility to adhere to the co-operative principle of autonomy and independence, which must not be undermined by engagement with statutory bodies.

In 2023, the Health Dialogue Forum published a set of agreed principles to build constructive partnership and collaboration between voluntary organisations and the State in the health and social care sectors. "Accountable autonomy", based on the concept advanced by Sabel (2018), was identified by the Forum as "a way of achieving the right balance between the necessary control by the State over policy and funding and recognising the autonomy and independence of the voluntary sector" (Health Dialogue Forum, 2023, p.18).

Another key principle agreed by the Forum is "collective leadership", which, in contrast to "command-and-control structures ... provides the optimum basis for caring cultures" (Health Dialogue Forum, 2023, p.23). Putting this principle into practice involves "distributing and allocating leadership power to wherever expertise, capability and motivation sit within organisations. This, it is suggested, creates a culture in which staff are encouraged to intervene to solve problems, to ensure quality of care and to promote responsible, safe innovation" (ibid., p.23). From a co-operative perspective, this would allow the types of innovation in care that we heard about from co-operatives that participated in this study.

The impending Statutory Home Support Scheme will be planned and administered through a HSE national-level shared service. Nonetheless, the new health regions provide an opportunity for closer collaboration with local stakeholders. This may facilitate the development of pilot initiatives, such as care co-operatives, in different health regions, while HSE national oversight can provide a forum for sharing of knowledge and experience of these initiatives.

It was suggested in one focus group that the Sláintecare Healthy Communities Programme, a pilot of 19 urban and rural areas identified as disadvantaged areas, supported by Department of Health, (also referenced in Section 4.4.3.1) could provide a useful testing ground for the community care co-operative model. This could also provide job activation and training for prospective care workers in disadvantaged areas, similar to the Italian social co-operative model, for example, in collaboration with Local Development Companies.

As part of the healthcare reform programme, the potential role of co-operatives should form part of the social dialogue around care. The independent Commission on Care for Older Persons, which commences its work in 2024, provides an opportunity to shine a spotlight on this potential.

5.4.5 The Role of Other Organisations

While the 'bottom-up approach', led by those who need care services and/or provide them, is integral to the co-operative model, the involvement of other organisations can make a significant contribution in terms of community activation, supporting enterprise development, and providing ongoing support and advice. This is illustrated by the case of the GCC. The MRCI conceived of and researched the concept of a workers' co-operative, while providing the forum for a group of migrant care workers to coalesce around the idea. It is likely that being anchored in the MRCI also gave the workers credibility with funding bodies.

We have already discussed the role of organisations such as ICOS in providing co-operative-specific advice and supports, and the possibilities of credit unions and social finance organisations to provideloan finance. There are also roles for other organisations in terms of awareness-raising, policy advocacy, animation of community initiatives, and fostering co-operation among co-operatives.

The Older People's Councils could provide a useful forum for social dialogue and engagement with policymakers on care co-operatives. Each local authority has an Older People's Council, which is intended to encourage and facilitate older people to take a more active role in their communities and have their views represented. As a national health programme co-ordinator outlined:

"I think the Older Persons Councils or the Age-Friendly structure within local authorities are a good kind of oversight structure because ... they have the ears of a lot of agencies at local level. I think they're gonna be key for ... any development of any type of co-operative initiative, because they have that bit of political teeth."

As demonstrated by some of the initiatives outlined earlier in this report, local development companies, which are based in territories across Ireland and have responsibility for delivering community-led local development using a multi-stakeholder partnership approach, could play an important role in animating and supporting communities to develop their own local co-operative enterprises. Supports may include networking, access to funding, training, and activation of local labour.

Co-operation among co-operatives is one of the seven co-operative principles. Several participants referred to the knowledge and expertise within Ireland's dairy and agricultural co-operative sector, which might provide a useful resource for start-up care co-operatives. While there were no participants from this co-operative sector in the study, there was significant interest from the credit union movement, which emerged as a natural fit in terms of their affinity with communities – both urban and rural.

We have already discussed the potential roles that credit unions could also perform in relation to provision of finance and awareness-raising. Leaders in the credit union movement who participated in the focus groups were very positive about the possibilities of engaging in a national dialogue on the care co-operative model and potentially offering support:

"We'd be advocating with credit union colleagues for credit unions ... to be more externally focused ... reaching out and to go beyond our narrow remit of providing

savings and loans facilities ... let'sbroaden our perspective in terms of what credit unions can really do for communities and society ingeneral."

Another CEO concurred:

"My role and that of the staff, along with the volunteer Board of Directors, is being a financial not-for-profit co-operative … and to broaden our horizons to build a better tomorrow for our community ... [R]egarding collaboration and creating the network of entities that are all trying to do the right thing, to be part of that, because it's very hard for co-operatives to do things on their own. And it's part of our own ethos that we would build on those foundation principles and co-operate with other co-operatives with regards to being more than just a financial savings and loans institution."

While emphasising the need for prudence in relation to assessment of risk - not just financial but equally reputational risks associated with any care co-operative failure, another credit union CEO emphasised the possibilities that could be realised:

"we can transform Irish society from grassroots level up with initiatives like this sort of co-operative .... Credit unions changed the financial services sector in Ireland. We were the first social enterprises. We've changed financial services. Can we actually do that again and let other organisations change other elements of our society?"

Stakeholders supported the idea of a national or all-island forum to explore the concept of care co-operatives and how they could be developed in Ireland. Key potential stakeholders like the Irish League of Credit Unions and Community Finance Ireland have an all-island remit, which could present opportunities for cross-border collaboration, although it is acknowledged that care commissioning differs in the two jurisdictions.

Finally, once care co-operatives begin to establish, they can also provide important peer support and mentoring to enable the scaling up of the model, in line with the so-called 'strawberry patch' principle that operates in Italian social co-operatives, as described by Conaty (2014).

Therefore, there is a wealth of institutional resources and expertise that a nascent care co-operative sector could leverage to support its development in Ireland.

6 Conclusions and Recommendations

This chapter begins with a summary of the key findings of the research study, first in terms of the experiences of those who give and receive care, viewed through the lens of the social-ecological framework, and second, focusing on the potential of care co-operatives to provide care in a way that responds to many of the problems inherent in the current system of care. The chapter closes with recommendations to progress the exploration and development of care co-operatives in Ireland.

6.1 The Social-Ecology of Care

The social-ecological framework offers us a mechanism for distinguishing levels of affective relations (the giving and receiving of care) and for appreciating how and why they matter. The 'Individual' and 'Close Relationships' level of the social-ecological framework correspond with the primary care relations or what Lynch (2022) calls "love labour". They tend to be carried out within the private domain of the home and among families. Moving into the public sphere, one finds secondary care relations at the 'Community Level', ranging from volunteerism to paid care work, that are carried out through a web of relationships interwoven across the social fabric of a local area. At the 'Society Level' are tertiary care relations such as solidarity, including with unknown others, for working together towards the common good. Ideally, public services, such as the national care system, including home care, would be designed, developed and operated on the basis of tertiary affective relations.

6.1.1 Individual

At the level of the 'Individual', the study heard that people wish to be able to 'age in place' both as an expression of their autonomy and desire to live where and how they choose, as well as to maintain their established web of relationships. Primarily, older people would like to remain in their own homes, but failing that, they might consider another house within their local community that is better suited to their evolving capabilities as they age. Ageing in place would enable them to meet their essential and lifelong human needs for both authenticity (self-expression) and attachment (social connectedness) within a familiar and ideally comforting milieu. Perceived benefits outlined included longer life expectancy, better quality of life in older age (including because of living among younger generations), and feeling needed, relevant and connected with significant others. The diversity and intersectionality of older people's identities, together with the variety of their individual circumstances and socio-cultural environments, call for supports to be adaptable and customisable. And the importance played by care in the quality of their lives, as it is across the human lifecycle, calls for supports to be appropriately resourced.

However, the experience on the ground revealed barriers to being able to age well in place, including a narrow medical model of homecare and a lack of affordable and accessible housing stock. This left older people uncertain about their future and in fear of premature admission to a nursing home.

6.1.2 Close Relationships

At the next level of 'Close Relationships', it became clear that planning for and then managing one's care in older age happens in the context of relationships with significant others, such as intimate partners and adult children. Care is a relational process in which

loved ones tend to play a vital role. Ideally, care happens in a reciprocal, mutual aid relationship, but it can be a strain for families. The nature of care relationships varies according to family structure, size, relationship dynamics and the situations of individual members, giving rise to much variation in care planning and practice at this level. In light of the variety of family circumstances, and the importance of family care, supports at this tier similarly needed to be adaptable, customisable, and appropriately resourced.

In the absence of a care continuum that could offer stepping stones of increasing support as older people's circumstances changed over time, loved ones and families were left trying to meet the gaps themselves. For those with the means and capacity to do so, this might include making adaptations to an existing house, or building a new, smaller dwelling informed by universal design principles to extend older people's capacity to age well in place for as long as possible. State bureaucracy and specialist knowledge could pose issues here.

The research study heard testimonies from older people of their own efforts to plan for the future for their peace of mind and/or out of consideration for adult children, but it also learned that they struggled with limited knowledge about the care system as they tried to navigate it. Financial means, personal capacity and professional experience also influenced the success of their planning. Others who were single, did not have children or were estranged from their siblings, described trying to plan for their future within the context of a lack of close family support to which to turn, and there was some interest in exploring shared living arrangements. Professionals shared experiences where families appeared to relinquish responsibility for a parent or other older relative to their care workers.

Mostly, the research documented relatives helping older people with house adaptations and/or becoming family carers to loved ones, including some adapting their own homes to accommodate a parent. In terms of the implications this had for their own livelihoods, some family carers combined caregiving with work while others left jobs to become a family carer, including several who returned from overseas. Possible consequences of being a family carer included negative impacts on their well-being and their income.

6.1.3 Community

As the Irish saying goes, "ar scáth a chéile a mhaireann na daoine"; people live in each other's shelter. At the level of 'Community', individuals and families living in the same place have more opportunity to meet one another, form friendships and become networked into the wider web of relationships of mutual aid or interdependencies that can exist within a locality. Given the right conditions, such relationships may coalesce as 'community spirit' or what is also known as 'social capital'. This can manifest as informal peer support or more structured volunteerism for the common good. Thus, community is an important site for fostering, deepening and harnessing secondary affective relations among local households and families, together with local groups and organisations, including services themselves. The strength of affective relations in a community can determine the emergence, development and running of bottom-up, volunteer-led care initiatives, as well as community-based service provision for older people in their homes. These include initiatives that deliver the types of adaptable and customisable care which empower people to age in place, such as meals-on-wheels, home visits, household maintenance, or help with transport to social activities and

medical appointments. It is achieved through the relational framework of 'community' and this is the fertile ground in which cooperatives, including in home care, may take root. A service that is community-based can plug into the social capital of local mutual aid relationships, both benefitting from and contributing to it. This was exemplified in the study by examples of the high regard in which local care services are held, as well as by the lengths to which care workers and health professionals at community level might go in order to advocate and collaborate for the welfare of local care recipients and their families. Examples of community-led responses to local gaps in care services included Connemara Care developed through the LDC FORUM Connemara, along with RHS Home Care initiated originally by a community group in Roscommon. However, the research also heard about the impact of social and commercial services being withdrawn from local areas through economic restructuring, a feature of neoliberal capitalism, which left residents increasingly car-bound or reliant on online services, and with fewer opportunities to meet one another, nurture relationships of mutual aid, and become part of a community of care. By eroding social capital in this way, the prevailing economic system is unravelling the social fabric of communities and, with it, their capacity for self-help.

To counter the social isolation experienced by givers and receivers of care within the private domain, research participants shared a desire for local, open-door venues where 'care' might be brought out into the public domain and made visible at community level. Along with offering authentic communal spaces of care to support people to age well in place, the resulting endorsement of affective relations could elevate public consciousness towards care so that it might become valued and rewarded appropriately in the political and cultural systems. Such endorsement, Lynch (2022) points out, is the necessary precursor for care to be valued and rewarded in the economic system too.

6.1.4 Society

At the last level addressed in this study, that of 'Society', the research highlighted that people are struggling to age well in place due to a range of issues beyond their control. These issues lead back to the State, which plays the dominant role in the system from designing, planning and resourcing care services to commissioning, regulating and monitoring their provision.

The value system underpinning care in Ireland was called into question by the failure of the State in its own duty of care to older people, to their families and to care workers. With older people expressing concern and fear for their own future care prospects, family carers struggling to sustain their care of loved ones due to inadequate supports, and care workers being driven from an uncaring sector, the testimonies revealed an uncaring system, where those who give and receive care are not at its heart.

Specifically:

The current home care system is made up of a profit-driven private sector, cost efficiency-driven public sector and an under-resourced community and voluntary sector. The conveyor-belt system that ensues leads to the disrespect and disempowerment of the givers and receivers of care. The resulting staff burnout,

combined with poor terms and conditions of care work, is leading to staff shortages and to older people together with their families struggling with inadequate care services.

State bureaucracy (e.g. to avail of home adaptations through the local authorities or the Fair Deal scheme through the HSE for statutory support with nursing home costs) is experienced as a barrier to overcome rather than an enabler of access to essential supports. So too is the HSE's commissioning of services from care providers. This raises concerns about the administrative procedures of any future statutory support scheme for home care.

The current narrow medical model of home care prioritises personal care without regard for older people's need for a much more comprehensive range of social care in order to age in place.

The lack of a care continuum across the lifecycle means that the system cannot offer the necessary range of supports, housing options and living arrangements, and this leads to the premature institutionalisation of older people within hospitals or nursing homes. As well as being the most expensive options, this goes against the wishes of most older people (and their loved ones) who would much rather age in place, among their families and within their communities.

Failure to plan, design and resource the care system appropriately is also evidenced by ad hoc service provision with variation in terms of location, hours of operation and quality of service. It is all a long way from the vision of Sláintecare.

6.2 Desired Care System

The need for a root-and-branch transformation of home care provision offers an opportunity. It is driving the impetus for social innovators – individuals, organisations and communities – to respond to the failures and gaps in the current system. Through grassroots action, they are developing building blocks for a reformed and desirable system, one that appropriately values and rewards care.

For example:

Social innovators are calling for a paradigm shift that puts those who give and receive care at the heart of home care to ensure both great care and great jobs. The GCC and Equal Care Co-op are two organisations championing this fundamental change and pioneering its implementation in Ireland and the UK.

Older people, family carers and care workers are calling for home care that is planned, designed and resourced to work in service to care recipients and their caregivers, with supports that are readily accessible when and where needed.

All stakeholders are calling for a model of home care which acknowledges older people's diverse identities, circumstances and socio-cultural environments, responds to their changing needs over time and supports relationship-centred care.

Beyond the family home, they are calling for a diversification of care options at community level that will deepen responsiveness to the changing needs of older people.

Based on the findings of this research study, home care fit for people to age in place would:

- ✓ Be founded on a socio-economic system such as partnerism which *appropriately values and rewards care* so that affective relations are no longer invisible. Success would be evidenced by *appropriate care* for older people, *appropriate financial and other supports* for family carers, and *appropriate pay and conditions* for care workers.
    - As care is gendered and women are the default carers, appropriately supporting family carers and care workers would contribute to UN Sustainable Development Goal 5 'Achieve gender equality and empower all women and girls', especially Target 5.4 "Recognize and value unpaid care and domestic work through the provision of public services, infrastructure and social protection policies ...") and Target 5.5 "Ensure women's full and effective participation and equal opportunities for leadership at all levels of decision-making in political, economic and public life" (UN, 2023, p.7).
- ✓ Take a holistic, social care approach to home support, where a multi-disciplinary response results in wrap-around, bespoke and adaptable supports at household level. Some initiatives that have worked well to date tend to be led by experienced service providers and are co-ordinated across national and local government in collaboration with the community and voluntary sector.
- ✓ Adopt a lifecycle approach within a social-ecological framework, with a much stronger emphasis on the community level. Ultimately, people envisage home care that is integrated across the lifespan and embedded in community. This would offer a diversification of options enabling adaptability to evolving needs as people's capabilities change, while maintaining multigenerational communities of place.
    - Referring to the last two points, as supports would be aimed at people's personal and social care needs across their lives and within the community, this would contribute to 'UN Sustainable Development Goal 3. Ensure healthy lives and promote well-being for all at all ages', especially Target 3.4 to "By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being" (UN, 2023, p.4).
    - To achieve this lifecycle approach within a social-ecological framework, the State could take the following steps:
        - Adopt a position to halt and reverse the centralisation of essential services (including care) in larger urban centres. This would support the social fabric of communities that is vital to their sustainability and resilience, as evidenced during the COVID-19 pandemic.
        - Strengthen the resulting social capital within the relational framework of the community by empowering and resourcing community champions and groups to develop relationships of mutual aid, including as active partners in the care system. Desirable outcomes would be the development of community-led home care services such as care co-operatives and community-led public spaces of care such as open-door, adaptable, multigenerational centres for "staying socially connected" (Government of Ireland, 2019).
        - Ensure the availability of assorted, universally accessible and affordable housing stock in local areas by "promoting sustainable lifetime housing"

through the planning system (ibid.), including smaller, energy-efficient homes for older people.
    - Invest in a flexible continuum of care across a suite of home- and community-based living arrangements (or 'stepping stones') between the family home and the nursing home. This could build from the government's six principles of 'Housing Options for Our Ageing Population' together with the Age Friendly Programme's multi-agency and multi-sectoral approach to age-related planning and service provision.
- ✓ Employ a co-ordinated, collaborative and community development approach to planning, designing and implementing care services that promotes equality and social justice. The State's intention to work in partnership towards a shared goal and on an equal footing with community stakeholders should be genuine and unambiguous. Responsibility at State level would lie with e.g. a National Planning Unit for Care, as has been sought by the Joint Committee on Gender Equality (2022) and recommended by the Irish Human Rights and Equality Commission (2023). One multi-stakeholder partnership model is that of Sláintecare Healthy Communities, a collaboration across the HSE, local authorities and community organisations. Organisations experienced in community development and social inclusion (e.g. LDCs and FRCs) would be key partners for helping community champions and groups to develop and integrate a community-led home care system locally, but only if resourced to enable them to do so. There is also public support (77%) for a national non-profit organisation (likened to a 'GAA for Care') to help meet the challenges of Ireland's ageing society (Sage Advocacy, 2023) that might offer an umbrella support structure for community-led initiatives.
    - As working in partnership would not only harness social capital but strengthen the voice of often side-lined communities, this would contribute to 'UN Sustainable Development Goal 16. Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels', especially Target 16.7 to "Ensure responsive, inclusive, participatory and representative decision-making at all levels" (UN, 2023, p.20).

Altogether, these established approaches and frameworks, underpinned by a socio-economic system that values and rewards care, are proposed to successfully develop and deliver the home care envisioned in this study, as well as under Sláintecare: one that offers "the right care, in the right place, at the right time" (Department of Health, 2023a). This is the kind of system in which care co-operatives could play an important role.

6.3 The Co-operative Difference

6.3.1 Workers' Conditions and Job Satisfaction

Based on the accounts of founders of the GCC and Equal Care Co-op, and the focus group contributions of care workers who were already providing care through a worker co-operative, care co-operative development is a response to "conveyor-belt care" and represents the pursuit of a more humanised care system that respects those who provide and receive care. From a purely pragmatic perspective, respecting and valuing those who provide care is essential in order to address recruitment challenges in the sector. The experiences reported by focus group participants working in a care co-operative illustrate how such organisations can support the fulfilment of workers' human

needs, from decent pay and conditions to the higher-order needs of personal and professional fulfilment, as identified by Maslow (1943). In a sector that is characterised by low pay and poor conditions, better pay and conditions in care co-operatives can enable care workers to successfully meet their basic physiological and safety needs, including financial security, certainty around employment contracts, and pension provision. We also heard of positive experiences that relate to care workers' psychological needs for sense of belonging and esteem. These were linked to workplace relations, innovative work practices and democratic governance structures. Care co-operative workers spoke of how their expertise and insights were valued, how they were able to work in teams and provide peer support, how they could advocate on behalf of their clients, and how they were given more control over their own work. This empowerment, they believed, enabled them to deliver superior care because it is delivered in a waythat suits clients, which in turn leads to more job satisfaction. In a care system where workers are typically undervalued, innovative work practices implemented by the Great Care Co-op and Equal Care Co-op support the fulfilment of esteem needs. Furthermore, opportunities to serve on the board of directors opens up avenues to self-actualisation that could never be envisaged by most care workers outside of the co-operative sector.

As a small-scale study, a key limitation of this research in terms of care worker experience in a co-operative setting is that it relied on the testimonies of two care workers, both of whom were keen advocates for the care co-operative model. It is acknowledged that a larger sample of workers drawn from several diverse care co-operatives would be required to draw more definitive conclusions on the impact on workers' well-being and job satisfaction. However, it would appear that innovative work practices and opportunities to participate in the governance of the organisation are key sources of job satisfaction. Innovative work practices and, to some extent, worker representation in governance structures, could also be adopted in other social economy organisations in the care sector, such as social enterprises. However, the values and principles of the co-operative model provide a particularly appropriate organisational fit for less hierarchical management processes and more inclusive governance.

6.3.2 Quality of Care

We heard testimonies from care co-operative workers about the improved quality of care provided to clients. Negotiated care, or co-production, involves mutual agreement between care provider and care recipient on how care is to be delivered and, therefore, respectful relationships provide the foundation of good care. Care objectives are still achieved but the focus is on the client not as a unit with associated tasks to be completed but as a person with agency - a right to express their wishes and have them respected. In other words, it relates to the concept of human rights and equality.

Furthermore, relationship-centred care supports the idea of moving away from a medicalised version of care to a more holistic social care model that cares not just for the basic physiological needs of the human body but for the whole person and the complexity of higher order needs of connection, authenticity, esteem, and living life to one's full potential, including in old age. The capacity for co-operatives, as community-

based organisations, to support this type of care model was recognised by a range of focus group participants.

A limitation of this study is that it did not seek out testimonies from those who received care through a co-operative. This would be a difficult exercise to undertake in Ireland, given the limited development of care co-operatives. Such research is needed internationally but this was beyond the scope of this study.

6.3.3 Systemic Constraints to Delivering a Different Model of Care

Our engagement with focus group participants indicated a high level of interest and positive sentiment towards the co-operative care model. Participants saw how it could provide potential solutions for a system in crisis. However, there was a healthy interrogation of claims that co-operatives could alter the care system for the better. This reality check came from people with and without knowledge and experience of the co-operative model.

Firstly, a key concern expressed was that care work is simply not viewed as an attractive career path and, therefore, co-operatives will experience challenges in relation to recruitment and retention similar to those experienced across the care sector. If job satisfaction reported by the care co-operative workers in our focus groups can be delivered by more co-operatives, this may give them a significant competitive advantage when competing for workers. However, there may also be challenges in finding workers who want to take a more active role, for example, in the context of innovative work practices that involve care workers in the management of care plans; such innovations, while providing more variety and control for workers, do involve taking on extra duties. Furthermore, it cannot be taken for granted that care workers would want a more active role in running the co-operative. This would require wider research with a larger sample of care workers.

Secondly, there are significant impediments to co-operatives acting as change agents because of their incorporation into the wider care system as it is currently configured. While they enjoy more flexibility to deliver care in a different way when dealing with private clients, when they are providing care on behalf of a commissioning authority, such as the HSE, the scope to do things differently is more limited. Since it is unlikely that care co-operatives can be viable based on private clients alone, under the current system they would increasingly have to tender for public service contracts and compete with for-profit companies on the basis of cost. Furthermore, they have to compete with the 'fastest finger first' approach to requests to fulfil client care hours, where well-resourced, large for-profit operations enjoy an advantage. Small co-operatives, relative to larger companies, would also experience comparatively higher costs. Larger companies enjoy advantages related to economies of scale, such as in-house services that can support compliance and regulation. Also, when organisations providing commissioned care are not paid for care hours that are not delivered, for instance, while clients are in hospital, this would make it difficult for the co-operative to fulfil its commitment to provide consistent pay and hours to the affected care workers.

6.3.4 From Concept to Reality

6.3.4.1 Ownership

In the focus groups, the merits of different co-operative ownership models were discussed. In general, while some participants favoured community ownership as part of a multi-stakeholder model, all were supportive of strong worker representation. Having a stake in the co-operative's ownership was viewed by some as key to addressing recruitment and retention challenges in the sector. Empowerment of care workers was highlighted as an opportunity to 'deinstitutionalise' care workers and give them the confidence to advocate for better care.

6.3.4.2 Registration

The GCC is an example of an organisation that operates according to co-operative principles but has chosen to register as a company limited by guarantee (CLG). This is not uncommon in Ireland for two reasons: (1) a lack of familiarity with the co-operative model in the enterprise start-up support ecosystem, and (2) the perceived cumbersome nature of co-operative registration and subsequent auditing requirements compared with more conventional company registration. Proposed changes to co-operative legislation in Ireland may reduce some of the perceived disadvantages of registering as a co-operative. Registering as a co-operative from the outset offers a number of advantages, particularly in relation to providing appropriate structures, rules and processes to manage potential conflicts that inevitably arise in such a democratic governance model.

6.3.4.3 Viability of the co-operative enterprise

While the idea of a care co-operative is attractive for many reasons, the need to consider the resourcing, viability and sustainability of each proposed enterprise was highlighted.

In the context of a co-operative, resources include not just tangibles, such as finance; equally important are the intangible resources, such as committed support from a group of relevant stakeholders and willingness to volunteer their time and energy to support the endeavour. It is essential that co-operative boards are representative of the membership and collectively possess the necessary skill set to govern the enterprise and represent the interests of stakeholders. Other community-based organisations have faced challenges in recruitment and retention of volunteers. Anxiety about taking on positions of responsibility in older age or, for a family carer, overcommitting their time, are key considerations. The community hubs model being rolled out by the Great Care Co-op is an example of how care services can be embedded in communities without the need for separate boards to be established in each community. However, as co-operatives scale up their activities, care must be taken to maintain relational proximity of the board and the communities they serve.

In order to ensure financial viability, a care co-operative needs to identify and communicate a strong value proposition – what differentiates it from other care providers. In a market where many multinational care chains enjoy widespread recognition resulting from well-resourced marketing campaigns, new care co-operatives face significant competitive challenges. Given the limited size of the private home care market, even when co-operatives are able to secure business from private clients, they

are unlikely to be sustained by this. Under the current system, therefore, they will have to compete for HSE contracts.

While the small, local scale of care co-operatives offers many efficiencies, it can also lead to capacity constraints, where co-operatives may have to join with other providers in an area to meet 'quantum of service' requirements. Until care co-operatives emerge at the scale sufficient for the development of federated structures or co-operation among co-operatives, it may be necessary to collaborate with other organisations to achieve efficiencies in tendering processes and clinical governance compliance. Within a more ambitious change agenda, care co-operatives would be part of a widespread reform of the care system beyond the current commissioning model, which would provide better seedbed conditions for the flourishing of care co-operatives.

6.3.5 Developing a Supportive Ecosystem

Co-operatives are part of a social movement that seeks to provide more democratic, inclusive solutions to societal challenges. At the community level, including spatially defined communities but also communities of practice, the co-operative model enables individuals to collectively serve their mutual needs. Successfully raising awareness and understanding of the model is a prerequisite to the mobilisation of stakeholders to action. This presents significant challenges and requires the support of key stakeholder organisations that have access to networks. For instance, trade unions and advocacy groups may be important communication channels to enable care workers' engagement with the co-operative idea. Founders of the GCC, for example, enjoyed the advantage of having proactive support from the MRCI, which also collaborated with SIPTU and Family Carers Ireland to raise awareness and conduct more research on working conditions in the home care sector.

To be successful, co-operatives need 'bottom-up' impetus, but this then must be met with institutional scaffolds that can foster the development of viable care co-operatives; for example, organisations that can champion the cause or provide insights and expertise based on tried and tested co-operative models, conducive policy frameworks, supportive advisory services, access to finance, and business development supports.

County-level representative structures such as Older People's Councils could play a key role in terms of inclusive social dialogue around care co-operatives and the wider care system.

The focus groups heard from several credit union leaders who, despite their realistic appraisals of the challenges of creating a successful care co-operatives sector, were enthusiastic about engaging in any future, larger stakeholder dialogues to assess how credit unions might provide support in the spirit of the principle of co-operation among co-operatives.

The need for a dedicated care co-operative advisory service emerged as a priority in the context of sharing experience and expertise and avoiding the duplication of effort and experimental failures inherent in a fragmented approach. Ireland already has ICOS, a long-established co-operative representative and advisory body (dating back to 1894 when early co-operatives were founded in Ireland). To achieve care co-operative development at scale, a dedicated advisory or co-ordinating body may be needed, but the expertise of ICOS should be leveraged by any such entity.

6.3.5.1 Integrating care co-operatives into the care system

The active support of public sector bodies charged with responsibility for care services could strengthen the emergent care co-operative sector. Care co-operatives, in turn, could support the public sector in its duty of care by making care work more attractive and enabling older people and family carers to access high-quality care and support.

From a policy perspective, the views of CO-AGE focus group participants who had lived experience of the care system indicate a need for widespread reform. Policy reform can range from incremental change, where an emerging co-operative sector would create greater organisational diversity and consumer choice in the care system, to more radical reform where marketised care commissioning is replaced by partnerships between the State and co-operatives, social enterprises and other providers with a relationship-centred ethos and approach to care. Here we consider the scenarios along a spectrum of change.

An incremental change scenario would see measures put in place to support an emerging care co-operative sector to play a greater role in home care provision in Ireland. Under the current care commissioning system, public procurement legislation that complies with EU regulations but enables social value to be factored into the assessment of tenders would be essential to level the playing field between non-profit organisations, including co-operatives, and private providers. However, where co-operatives are successful in tendering processes, they face challenges in maintaining their distinctive service offering due to the pressure to conform to standardised requirements set by commissioning authorities. These challenges were highlighted by contributors to this study from care co-operatives in Ireland and the UK. The result is that private paying clients may experience customised care while care co-operatives have to negotiate and advocate for their care recipients funded through the public system to deliver equitable care.

The allocation of personal budgets is advocated by many stakeholders as a means to allow those who need home support to have greater discretion regarding who provides care and how it is delivered. There is considerable merit in such personal budgets. This approach would be consistent with a human rights-based approach to care in that it would recognise the autonomy and preferences of individuals receiving care. Enabling those who need care to exercise more choice would open up market opportunities for care co-operatives, who could compete for individual care recipients' business based on their distinctive service offering. Importantly, this would also give care co-operatives greater autonomy to provide care in a way that is agreeable to the care recipient and the caregivers. However, personal budgets are an important but partial solution and would not suit all older people. There is a risk that, given current care workforce recruitment challenges, some care recipients and their families may struggle to secure care workers who meet their requirements.

A more ambitious reform agenda could see public sector agencies actively supporting and having a stake in care co-operatives as part of a planned transition away from current commissioning processes, which tend to favour large care company chains. As discussed in Section 5.4.4.1, the State officially recognises the importance of, and pledges support for, the community and voluntary sector in strengthening the resilience and capacity for self-help within communities (Government of Ireland, 2019, p.19).

Appreciation of this sector was heightened by these organisations' agile response to the COVID-19 emergency, which was enabled by their embeddedness within communities and the social capital on which they thrive. While it is unlikely that the State will abandon subcontracting of care in the short to medium term, recent healthcare policy and strategy documents (Department of Health, 2023; Health Dialogue Forum, 2023) do proclaim an openness to working in constructive partnership with the community and voluntary sector. In particular, the Health Dialogue Forum's set of agreed principles are designed to enhance constructive partnership between this sector and the State. For co-operatives, the agreed principle of 'accountable autonomy' is important in terms of their responsibilities to remain autonomous and independent, while 'collective leadership' fosters "a culture in which staff are encouraged to intervene to solve problems, to ensure quality of care and to promote responsible, safe innovation" (ibid., p.23). This would allow the types of innovation in care that we heard about from co-operatives that participated in this study.

6.4 A Synthesis

The main purpose of this report has been to stimulate a national conversation on the future of care. We have focused specifically on exploring with stakeholders the potential of the co-operative model to empower care workers and care recipients, address problems of care worker recruitment and retention, and enable the delivery of high-quality care into the future. While this research focuses on care of older people, the co-operative model is of relevance to a range of social care provision, including care for people of all ages with disabilities or health issues, and childcare.

A key limitation is that we were able to engage with a relatively small number of stakeholders in each category who volunteered to participate in the study, including care recipients, family carers, care workers, and those with a potential professional role in supporting the development of care co-operatives. Given the small sample size, and the possible influence of self-selection bias whereby individuals who opted into the study may be more motivated to actively seek out alternative care models, their openness to the co-operative model cannot be assumed to be representative of the wider population.

Further research is needed to assess the appetite among care recipients, family carers and care workers to become involved in starting and actively sustaining engagement in care co-operatives. In some respects, it is easier to be a passive recipient of care than to volunteer time and energy in a collective social endeavour like a co-operative, though the results can be rewarding. A further question that needs more research is whether there would be a critical mass of care workers who would be sufficiently motivated by the rewards to invest their time and energy, particularly in the adoption of innovative approaches, such as organisational democracy and self-management. The co-operative model is democratic, participative and inclusive and, as such, brings with it responsibilities that not everyone is willing to accept.

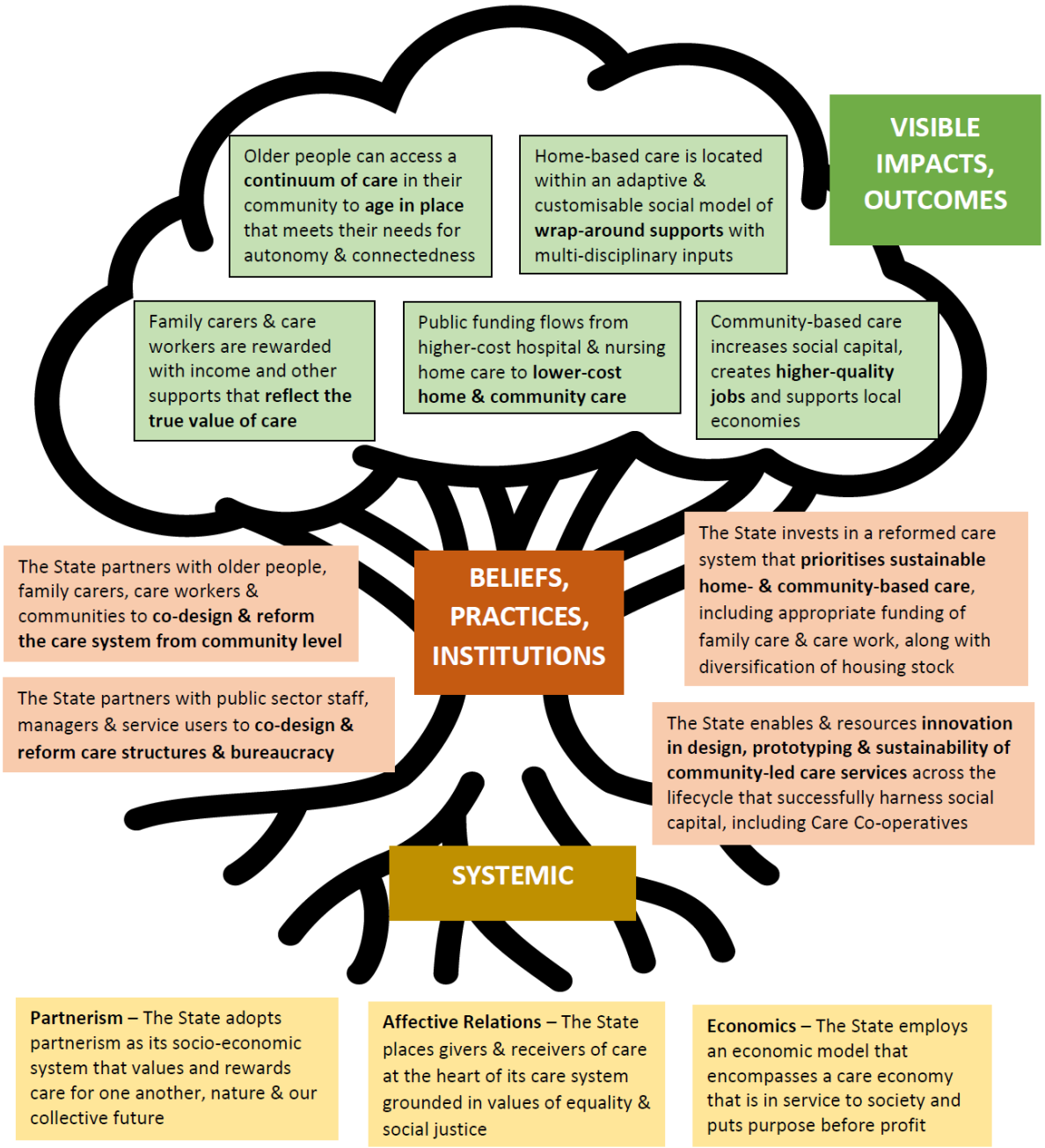
Further evidence is also needed on the international experience in terms of satisfaction levels of care workers and care recipients who have experienced the co-operative model.

We see this report as an invitation to stakeholders to explore the possibility of the co-operative model to create more organisational diversity within the care system. The co-operative model offers some very particular advantages related to empowerment of care workers and care recipients, where care is centred on the mutual relationship. By enabling a more active role for both parties in the relationship and affording an opportunity to stakeholders to play an active role in organisational governance, care co-operatives can satisfy higher order needs of esteem and self-actualisation, enabling care workers to reach their full potential and older people to continue to remain active members of their communities and society.

Realising the potential of co-operatives and the flourishing of relationship-centred care is contingent on a political and cultural reappraisal of the centrality of affective relations in a humane society. Moving care from the margins to the heart of Irish society is a prerequisite for ensuring that the socio-economic system truly values and rewards care across the life cycle. The resulting care economy can achieve downstream benefits that flow from empowered care recipients, care workers, families and communities.

Figure 6-1 synthesises these conclusions into an image of the envisaged care system that would follow a paradigm shift at the roots of the system, the implementation of beliefs, practices and institutions that could grow out of those roots and uphold the new system's values in society, and the visible impacts and outcomes that might be enjoyed across society as a result.

FIGURE 6-1: THE ENVISAGED CARE SYSTEM.



Note: Visualisation based on 'The Oppression Tree'[29].

[29] Source: https://coco-net.org/the-oppression-tree-tool/#:~:text=The%20Oppression%20Tree%20Tool&text=In%20this%20metaphor%2C,ideologies%20and%20institutions%20of%20oppression., accessed 13/10/2022.

6.5 Recommendations

The contributions to the current discussion made by this research and its recommendations are as follows:

1. Partnerism - A Socio-economic System of Care
    a. At the level of society, this research makes a case for embedding the care system in **a socio-economic system that values and rewards care** for one another, nature and our collective future. Partnerism offers a framework for making affective relations visible and for bringing about the paradigmatic shift in cultural values - as called for by participants in this study, Lynch (2022) and IHREC (2023) - that is needed to foreground care within a reformed care system in Ireland. A transition towards partnerism requires leveraging the four cornerstones on which social systems are built and maintained (Eisler, 1987).
2. The Four Cornerstones for Creating the Desired Care System
    a. The **cornerstone of gender relations** is very relevant in the area of care, where women are the default carers. Achieving gender equality is essential **to elevate the status of care relations and thus care work within society**. This will be evidenced in the appropriate valuing and resourcing of care by the State, and in a rising proportion of male caregivers in the private domain of family carers and the public domain of care workers into future generations.
    b. Eisler's cornerstone of family/childhood relations is expanded here into a **cornerstone of community/family/childhood relations** to encompass Lynch's (2022) affective relations with a spotlight on community. By framing care within the social-ecological framework, this research highlighted not only its relational nature, but the importance of the community level. It documented that social capital created through local relationships of mutual aid is a key asset in community-based care. Increasing and then harnessing social capital requires the State to **(1) strengthen the social fabric of communities through policies that halt and reverse the centralisation of services and (2) appropriately invest in community development to enable community-led innovation in care**. One pillar of community-led innovation in care includes the creation of public spaces of care. For example, participants in this research envisioned an open-door venue at the heart of the community and as familiar as the local school or church. It might entail re-imagining and re-designing **community centres as universally accessible, multi-functional and inter-generational spaces which celebrate and nurture affective relations across the lifecycle.**
    c. In terms of the **cornerstone of economic relations**, partnerism requires **an economic system that appropriately values care and resources it suitably to reflect this value**. Thus, Doughnut Economics, which envisages a 'safe and just space for humanity' within a 'regenerative and distributive economy' is proposed as a model for an economic system that will recognise care jobs as green jobs and achieves four essential outcomes: (1) appropriate care for older people, (2) appropriate financial and other supports for family carers, (3) appropriate pay and conditions for care workers, and (4) a care system that distributes by design the benefits of care work to those who co-produce

care, in contrast to the current marketised system where the wealth created is siphoned off to return a profit to investors.

d. The **cornerstone of narratives and language** will serve to **make visible and celebrate the centrality of affective relations in the flourishing of human capital** to answer Lynch's (2022) call to bring care out of the political and cultural underground and to "recentre care, equality and social justice as political values" (ibid.). This would raise awareness and understanding that care relations, from love labour to communities of care and societal solidarity, are what give and nourish life across the life cycle. Furthermore, family and community are where national policies, systems and structures meet with people's lived realities and where the consequences of any lack of joined-up thinking and practice by the State will manifest most negatively. Examples of siloed thinking and practice in this study included State bureaucracy that acted as a barrier to accessing essential support, the unsuitability of the narrow medical model of home care and the lack of a care continuum between home and nursing home. Instead, **a worldview that encourages systems-based thinking, multi-disciplinarity and a life-cycle approach is required to create an integrated care system**, not only for older people, but also for people living with disabilities or complex needs, and for children. Focusing on home care, such a system would include: (1) a social model of home care at household level with the adaptability to deliver bespoke and wrap-around supports and (2) interwoven public sector strands (such as local planning to ensure a diverse range of housing stock) at community level. It would also encompass a supportive environment for community-led innovation in care, such as care co-operatives.

3. Care Co-operatives

a. Putting care co-operatives on the agenda

One of the objectives of this study was to raise awareness of the co-operative model among interested stakeholders and to elicit their responses to the model as an alternative way of providing care and/or working in the care sector. The response to the model was generally positive but it is acknowledged that the findings are based on a small-scale study. We offer the following recommendations to build on this research.

i. A prerequisite to the development of care co-operatives in Ireland is **the need to raise awareness of the model** and how it could be applied to the societal challenges associated with providing high-quality, rights-based care to an ageing population, and indeed to all others who need care. This would involve engaging with stakeholders, including statutory organisations responsible for organising and providing home care support, professional and family caregivers and care receivers, and communities. The wider co-operative sector could play a key role here. Ireland has long-established and newer co-operatives in a range of sectors, most notably agriculture, financial services, and rural and community services. Credit unions, for example, are the most prevalent co-operatives in Ireland, serving approximately 3.6 million members in communities throughout the country, and enjoy high levels of trust among their members. Well-established, trusted co-operatives, co-

operative networks and representative organisations would provide a credible channel for communicating the co-operative model. Reaching the target audience could be critically dependent on collaboration with organisations such as trade unions, age advocacy and carer advocacy groups, local authorities, local development companies and community groups.

ii. The awareness-raising and communication campaign outlined above should not be unidirectional; rather, it must be conducted as **an interactive, multistakeholder dialogue**. Since the sustainability of co-operatives relies on the support of a group that coalesces around a bottom-up initiative, care co-operatives only provide a solution where there is sufficient stakeholder 'buy-in'. Part of this dialogue involves **an exploration of the appetite among care recipients, family carers and care workers to become involved in starting and actively sustaining engagement in care co-operatives**, and also whether there would be a critical mass of care workers who would be sufficiently motivated to invest their time and energy in the adoption of innovative approaches, such as organisational democracy and self-management.

iii. Care co-operatives offer potential solutions to the problems of 'conveyor-belt care' highlighted by participants in this study. The concept of 'design for use' rather than for profit, and the opportunities for co-designing high-quality care, empowers those receiving care and family caregivers to influence how older age is experienced. Furthermore, by improving working conditions, care co-operatives can help to address lack of capacity in the home care sector due to inadequate labour supply. The potential for stakeholders to work collectively to solve such problems should be of interest to statutory organisations with responsibilities for home care provision. **Therefore, the concept of care co-operatives needs to form part of a national social dialogue on care. The Commission on Care for Older People, set to commence its work in 2024, represents a key opportunity to introduce care co-operatives to this dialogue and onto the policy agenda.**

b. Supporting the development of care co-operatives

As co-operatives are founded on bottom-up motivation and commitment, and while the model offers unique opportunities for the co-design of care by service users and other stakeholders, as well as better pay and conditions for workers, and greater job satisfaction, it cannot be imposed as a universal solution to organising care provision. However, where communities or groups of workers are convinced of its merits and wish to pursue the development of a care co-operative, there needs to be an appropriate institutional framework to support their endeavours.

i. This study highlighted the need for **a dedicated co-operative advisory service** to support the development of care co-operatives, and to avoid the duplication of effort and repeated mistakes that would likely occur in a fragmented movement. As well as providing guidance to care co-operatives and developing templates for co-operative

development, this body would act as a repository for shared learning and tacit knowledge acquired by fledgling care co-operatives. This might be a new organisation or, more likely, particularly at the early stages, a unit within an existing co-operative support organisation, such as the Irish Co-operative Organisation Society (ICOS). **Collaboration with statutory organisations, such as the HSE, and with social finance organisations, would be key to providing a comprehensive, dedicated service to support care co-operatives to navigate the legal, regulatory and bureaucratic systems, develop appropriate structures and rules, devise feasible business models and access funding.**

ii. The integrity of the co-operative model depends on co-operatives living out the values and principles inherent in co-operativism. **Appropriate structures and rules are essential to support the democratic process at the heart of co-operative governance.** It is recommended that care co-operatives give due consideration to registering as co-operatives. Impending changes to legislation are likely to make registration and compliance less burdensome.

iii. As a further enabler of co-operative action and to safeguard the integrity of the co-operative model, **education and training** is required to support the elected co-operative officers to perform their roles effectively and to foster democratic governance and participation by members.

iv. This report has highlighted two care co-operative ownership models. The worker co-operative model provides a way for care workers to improve their working conditions and job satisfaction, while also enabling improvements in the quality of care. The multi-stakeholder model offers a more formal structure for the needs of care recipients and their advocates to be represented. It also offers opportunities for public sector organisations to play a more active, embedded role in co-operatives, but with limited voting rights. By its nature and composition, **the multi-stakeholder model is more complex, requiring well-defined co-operative structures and rules to accommodate the balancing of different members' interests**.

v. As a highly regulated sector where access to clinical governance expertise is essential and, under the current system, capacity to deliver services across a defined area is essential, **scale is a key consideration for emerging co-operatives**. The GCC model of scaling up by adding new **local hubs** is at an early stage. This model offers a way for co-operatives to scale up and extend their services to several areas rather than starting new co-operatives in each community. **An important consideration in the scaling process is to maintain equitable representation and embeddedness in the various communities served**. A federated model would also allow local co-operatives to maintain their independence and autonomy while benefitting from shared services that enable them to meet compliance requirements and achieve efficiencies.

vi. This report has highlighted the many advantages offered by care co-operatives in terms of empowering those who give and receive care. However, it cannot be assumed that co-operatives inherently provide better working conditions and/or a better service for clients. **Additional training is required to equip care workers with the skills and knowledge required to adopt innovative work practices, such as those implemented in care co-operatives encountered in this study, and to provide safe, high-quality care.**

vii. The Health Dialogue Forum emphasises that the set of agreed partnership principles between the statutory and voluntary sectors need to be "lived rather than laminated", and that specific projects provide an opportunity to "address fundamental problems or issues within the health and social care system .... [and] can help to deliver better quality people-centred services" (2023, p.19). The **development of a State-funded pilot programme to co-design and develop prototypes of community-led care, in partnership with relevant statutory organisations**, would provide an opportunity to 'live' the partnership principles, by supporting improved working conditions for care workers and improved experience for those receiving care.

viii. More research is needed to **deepen learning from international experiences of care co-operatives** working in collaboration with public sector partners. In particular, there is a need to learn about the **challenges of maintaining organisational autonomy and resisting cultural assimilation** when co-operatives become part of a care system that is characterised by predominantly efficiency-driven, one-size-fits-all, hierarchical relationships. This autonomy includes the freedom to deliver care equitably in a way that is compliant with regulation but is co-designed by care workers, care receivers and their advocates, regardless of whether care is provided directly to private clients or on behalf of statutory care commissioning organisations. Such autonomy also safeguards the capacity to provide excellent working conditions for care workers.

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