Paid Companions: A Private Care Option for Older Adults*

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RÉSUMÉ
Les compagnons rémunérés, fonctionnant d'une façon autonome ou par le biais des agences privées de soins à domicile, effectuent une variété de services pour les personnes âgées nanties qui peuvent se payer pour le soutien privé dans leurs maisons et dans les centres qui dispensent tels soins. Cette étude a examiné le travail accompli par les compagnons rémunérés, en s'appuyant sur des entretiens semi-structurés, ouverte, des entrevues en personne et d'élicitation des photos auto-pilotées (par lequel les individus prennent leur propres photos et en discuter plus tard dans les entretiens) avec 30 participants (15 compagnons, 8 clients et 7 informateurs clés). Les résultats ont révelé que, de plusieurs façons, les services fournis par les compagnons pour les clients qui vivent dans leurs propres maisons ressemblent aux soins à domicile basés sur les tâches, mais l'accent mis sur le travail est différent. Les relations sociales et émotionelles avec les clients sont au centre de leur travail. Les compagnons basés dans les établissements jouent un rôle unique, remplissant le vide laissé par les compressions budgetaires des ratios de dotation en personnel, qui garde les résidents âgés, souvent atteint de démence, impliqués et engagés dans le monde.

ABSTRACT
Paid companions, operating either independently or through private home care agencies, perform a variety of services for financially secure older adults who can afford to pay for private support in their homes and in care facilities. Drawing on semi-structured, open-ended, in-person interviews and autodriven photo elicitation (whereby individuals take their own photos and discuss them later in the interviews) with 30 participants (15 companions, 8 clients, and 7 key informants), this study examined the work performed by paid companions. The findings revealed that, in many ways, the companion-provided services for clients living in their own homes resemble task-based home care work, but the work's emphasis is different. The social and emotional relationship with clients is the central focus of their work. Facility-based companions provide a unique role filling the care gap left by government cutbacks to staffing ratios which keeps elderly residents, often with dementia, involved and engaged in the world.

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Over the past 35 years in Canada, a particular type of caregiving has slowly emerged in private health care services for older adults – *paid companions*. To date, while considerable scholarly research has been conducted on care and caregiving, paid companions represent an unrecognized type of caregiver in our society, one that also reflects an explicit research gap. Very little is known about the prevalence, socio-demographic characteristics, and functions of paid companions in contemporary Canada.

Due to the ambiguities connected to the term and reflected in the nature of the work, it is difficult to provide an exact definition of *paid companion.* These complexities will be discussed in depth later in this article, but for now I will clarify the differences between the two primary types of companions: home-based and facility based. Home-based companions perform work very similar to the task-based labour of home support workers, but for companions, it is the client relationship that takes precedence over the task-based work they perform. Facility-based companions, on the other hand, offer only emotional and social support, with no personal care except for assistance with feeding.

Drawing on data from 30 study participants (15 companions and 8 clients, as well as seven key informants who were interviewed to provide contextual information on paid-companion private agency work), I examined the development of paid companion service and the nature of the work provided by companions to their older adult clients. To do so, I used two qualitative methods: (a) semi-structured, open-ended, in-person interviews, and (b) autodriven[1] photo elicitation (a process whereby the research participants take photos that they then discuss in interviews). This research was informed by a theoretical perspective within the context of critical theory and political economy, while also drawing on a phenomenological approach in order to develop a more thorough understanding of the motivations and relationships of paid companions and their clients.

Although the concept of companions is not new and can be traced to Victorian-era companion services in England, the form taken by today's paid companions is new: it reflects the contemporary socioeconomic climate of self-care, individual responsibility, and choice. The political economic framework of neoliberalism has shaped the restructuring of Canadian public health care for more than two decades, eroding services and the quality of care (Williams, Deber, Baranek, & Gildiner, 2001). Government policies, in line with neoliberal concerns with cost-efficiency and profit motives, have shifted responsibilities for care from formal institutional care to informal, community care (usually with the responsibility falling on female family members who are generally employed outside the home) (Baines, Evans, & Neysmith, 1998; Chappell & Penning, 2005; Hooyman & Gonyea, 1995; Penning, Brackley, & Allan, 2006). This shift, however, clashes with the reality of fewer family members being available to provide eldercare, borne out by well-documented declines in fertility rates and numbers of children.

Canada's seniors represent Canada's "fastest-growing age group" with an "estimated 5 million Canadians age 65 or older in 2011, a number that is expected to double in the next 35 years" (Human Resources and Skills Development Canada, 2011). These seniors are "enjoying longer life spans and better health than ever before" (Health Canada, 2010). Nevertheless, there is a growing fear of a "catastrophic" landslide of an aging and frail population who will drain the health care resources of the younger generation (Binney & Estes, 1988; Hooyman & Gonyea, 1999). The social construction of the "catastrophic demographic" perspective, which has its roots in neoliberalism, has served in Canada as one of the justifications for health care restructuring. This includes the privatization of health care services, often through the practice of *profitization*, which involves the contracting out of public services to private companies (Armstrong, Armstrong, & Scott-Dixon, 2008. p.10), as well as the reinvention of caregiving conceptualized as a traditional model of care, reinforcing the ideology of familialism[2] (Hooyman & Gonyea, 1999).

As with previous generations of seniors, the majority of older people today prefer to remain in their own home as they age (Butler-Jones, 2010). To do so, however, often requires support and services. Yet, unlike governments in the Nordic countries – such as Finland and Iceland that have invested in home support services to assist people to age in place – in Canada, provincial and federal governments have drastically reduced publicly funded home support that would enable older Canadians to remain at home (Benoit & Hallgrímsdóttir, 2008).

In the 1990s, British Columbia was one of the first provinces to implement health care reforms. Home-based care, which lies outside the protection of the Canada Health Act of 1984, has been extremely vulnerable to the neoliberal economic agenda. Once the locus of care is removed from the protection of hospital and/or physician services covered under the Canada Health Act, these services are opened up to market and business interests, such as private insurance companies, and private home care agencies (Williams et al., 2001). And while community-based long-term care (LTC) can involve better and more equitable, as well as more cost-effective, care for the elderly, this can only be the case if there are adequate resources and funding for community care (Chappell, Havens, Hollander, Miller, & McWilliam, 2004). Yet this is increasingly not the case in the current political economic environment. In a review of provincial data from 1995 to 2005, McGrail et al. (2008) noted that the percentage of seniors (over age 65) who received home health services declined from 13 per cent to 9 per cent.

In addition, Purkis, Ceci, and Bjornsdottir (2008) pointed out that home care is perceived as a "highly structured and scarce commodity," bureaucratically rationed by case managers who assess and decide how many hours of support a care recipient and family can receive (p. S32). These determinations are conducted in such a way as to appear to provide everyone with equal home care resources; the reality, however, is that the home care resources actually provided are dramatically insufficient, with care recipients' female relatives typically having to provide most of the needed care.

At the same time, government cutbacks have also directly impacted formal institutional care. Funding cuts to hospital and LTC over the past 10 years have outsourced food and laundry services, and "reduced the hospital workforce by up to 10%, and utilization rates in the hospital sector (to 850 beds per 1000 population)" (Fuller, 1999, p. 8). In 2001, staffing levels in residential care facilities in British Columbia were far below the minimum recommended by researchers and experts, with wide variations evident across the province (Hospital Employees Union, 2009, p. 13). These cutbacks have taken place even as dementia rates among seniors are increasing, with institutional care often a necessity at some point in the trajectory of the illness. According to a 2010 Public Health Canada report, "dementia impacted over 400,000 Canadians in 2010 with those numbers expected to double within 30 years" (Butler-Jones, 2010, p. 2).

According to Armstrong, Armstrong, and Scott-Dixon (2008), the restructuring of the Canadian health care system is exemplified by a shift into privatization and "new public management". This can be seen in the Public-Private Partnerships (P3s) taking place today in British Columbia in health care facilities. Whereas previously LTC facilities in British Columbia were either public or private facilities, today a number of public facilities have been replaced with P3s, which are privately owned, for-profit LTC facilities that nevertheless receive government funding. The BC Health Coalition (2008) argued that P3s are more expensive to run; are not accountable to the public because they represent private business interests (despite the fact that they receive government support); and the quality of care suffers because the emphasis is on profit, not good-quality health care. This shift has resulted in changes to dietary, housekeeping, and laundry services in the form of drastic cutbacks to staffing levels and wages, and/or in outsourcing to private companies. All these changes have directly affected ancillary workers and have negatively affected the quality of health care, (BC Health Coalition, 2008).

These funding cuts embedded in government policy at both the community and LTC-facility levels have also opened the door to the expansion of private home care services that employ paid companions. Furthermore, the resultant shortage of beds and unabated need for care foster the public's acceptance of for-profit, sometimes totally privately supplied, services. Within this socioeconomic and socio-demographic context, some seniors and families, feeling the impacts of the cutbacks to health and social services, have turned increasingly to other care alternatives to fill care gaps. Consequently, a new type of caregiver – the paid companion – has become more prominent.

Paid companions have become increasingly popular over the past three decades. Although my research did not focus on the historical aspects of companion service and so is limited in this respect, the findings indicated that prior to the early 1970s, family members, friends, neighbours, and volunteers donated the extra care and support that individual patients needed in hospitals and LTC facilities. But in the 1974–1975 time frame, my research showed that families started to request additional support for their relatives beyond what hospital paid staff and volunteers could provide at the Gorge Road Hospital, Victoria, British Columbia. In response, the Gorge volunteer coordinator established a paid companion service for residents and their families (10–12 female volunteers were hired on a part-time basis as companions). The term companion was chosen to differentiate the workers who provided paid visiting services to clients from the volunteers (although the care they provided was identical).

These early companions working at the Gorge Hospital provided emotional and social support to residents through their visiting services, which consisted of conversation and listening, accompaniment on walks, respite care, and palliative care, mirroring the work done by LTC-facility-based companions today. And, reflecting companion work today, no personal care was provided at that time due to hospital and/or union regulations with the exception of assistance with feeding. The primary difference between the services provided by the 1970s Gorge companions and facility-based companions today is the restriction placed on taking residents out of the facility. Gorge companions were allowed to take residents outside the hospital for a walk but only around the facility grounds. Today, while agency-based companions face the same limitations (unless they are hired to provide transportation services), independent companions do not. They often take their clients out of facilities on outings: for a drive, lunch, swimming, or walks in a park, thus creating a way for institutionalized elderly people to engage in the larger world around them.

Private home care agencies were also in evidence as early as 1975 in Victoria, when Alpha Home Health Care, a locally family-owned and operated company, was established, offering private home care services, including paid companions. This time frame coincides with the experiences related to me by two paid companions who began working in their profession over 30 years ago. Both companions initiated their careers with private home care agencies in the 1980s when there were only two to three private home care agencies operating in Victoria. In 2011, there were 16+ private home care agencies listed in the Victoria phone directory, with additional companies offering services specifically oriented to seniors, such as transportation, downsizing/moving assistance, financial planning and asset management, or gardening assistance. Although my research is limited in this respect, in addition to private agency companions, it is most likely that paid companions were also available 30 years ago offering independent companion services. In sum, from a historical perspective there are many aspects of private home care agency services and paid companion work that we know little about, and that call for further research.

Review of the Literature

Although there is virtually no available literature specifically focusing on paid companions, considerable research has been conducted on formal and informal care (Chappell, 2008; Ward-Griffin & Marshall, 2003), which includes home and facility-based health care workers. In addition, research has been conducted on the care needs of those with disabilities (Ungerson, 1999, 2004; Rivas, 2003). This literature review draws from the earlier research to provide a context for understanding paid companion work.

Two main themes surface in the literature on formal and informal care: the blurring of boundaries between formal and informal care (Ward-Griffin & Marshall, 2003) and the growing commodification of both formal and informal care (Ungerson, 1997). These processes are, in turn, linked to neoliberalism through government-implemented health care policies which replace government support of public services with privatization or profitization of public services, and through an internalization of the neoliberal ideology (or values) of individual responsibility and choice (Hooyman & Gonyea, 1995; Navarro, 2002). When families for example, internalize the ideology of individual responsibility, hiring a paid companion for a family member in LTC becomes a 'choice' they are able to make. Emphasizing 'choice' removes the socioeconomic context in which this choice has been made, undermining the fact that choice in this framework is part of an inequitable system of care. In this way, the interdependent and collective model of health care, which has been the basis of universal health care in Canada, is being replaced by an economic, market-driven model of care (the *marketization* of care and health care services) (Baines et al., 1998).

Home care work, which includes kinds of work similar to that of paid companions, possesses parallels with informal caregiving. Home care work also reflects inequalities based on socioeconomic status, race, ethnicity, and gender (Benoit & Shumka, 2009; Treloar & Funk, 2008). As Ungerson (1997) and other scholars have pointed out, "economies of care" (Evers, 1994) may additionally transform the relationships of the people in them, and rather than liberate women, they may do the opposite: reinforcing care work as "women's work", contributing to further gender and class exploitation (Ungerson, 1997; Hooyman & Gonyea, 1995). Ungerson, furthermore, suggested that this might even lead to the development of another form of domestic service class, which is yet another form of care commodification.

Due to health care restructuring that has resulted in the offloading of care to families, home care is one of the fastest growing professions, yet it is not well paid. For example, the median hourly wage in 2009 for the average home care worker was $7.81 in the United States and $10.50 in Canada (Benoit & Shumka, 2009, p. 14). Home care workers are now performing many of the tasks previously done by families: cooking, housekeeping, shopping, basic personal care (Karner, 1998, p. 71). Additionally, paid home care workers become unpaid, informal caregivers when they put in extra hours for no pay in order to provide the assistance care that recipients need. A related development is that family members without government support – or who have limited caregiving time due to work commitments – hire companions who then become a type of commodified *fictive kin* to their elderly family members. These home care workers depict their relationship as being "part of the family," describing their emotional labour as outside the confines of work or as non-work (Aronson & Neysmith, 1996, p. 66).

The perception of certain kinds of jobs as non-work dismisses and diminishes home care workers, a situation that finds parallels in the invisible work performed by non-direct health care staff, such as dietary, housekeeping, maintenance, clerical, or laundry workers. Armstrong et al. (2008) in their Canadian study on ancillary workers argued that the contributions these workers make to health care are greatly undervalued and, further, are made invisible by the gender bias present in this type of work. Regarded as a type of women's work that involves neither skill nor responsibility, ancillary work is defined as "out of care" work related to the hotel service industry rather than to health care (Armstrong et al., 2008).

The concept of devaluing home care work by rendering it invisible resonates with Rivas' (2002) research on personal care attendants and their disabled clients in the United States. She suggested that the illusion of independence required by the dependent care receiver is maintained by making the careworker – rather than the careworker's labour – invisible. This artificial invisibility has a number of features, the most important being the effective use of *emotional labour* (Hochschild, 2003) by the personal care attendants. Although emotional labour is a contested term in sociological literature accompanied by debates concerning care and economic transactions, in this particular instance *emotional labour* refers to workers' striving to maintain an emotional "distance" when performing intimate tasks associated with bodily functions, such as changing the diapers of a dependent person. Another important factor that maintains the invisibility of the work and the worker is the attitude of the care attendant towards the work they do; if care workers enjoy the work they do, the "labour" aspect of their work effectively disappears (Rivas, 2003, p. 76).

Time and overtime hours represent another issue that overlaps with research on long-term care facility workers in both the United States and Canada. The literature reveals that time becomes problematic both in terms of clients' expectations and of the inadequate amount of time allotted by facilities or home care agencies per assignment. In a study conducted by Sims-Gould and Martin-Matthews (2010), Canadian home care workers emphasized that building relationships with clients was essential to service delivery and job satisfaction. However, with the agency focus on schedules and task-based assistance, workers are prevented from offering the "personalized care" to their clients that they would like to give (Sims-Gould & Martin Matthews).

Home care work is also physically and emotionally demanding, often causing job-related injuries and other health-related problems. Home care workers are also exploited through the additional unpaid hours of work they frequently contribute out of concern for their clients' well-being, who are also often "poor in health, lonely and as financially constrained as the home-care workers themselves" (Benoit & Shumka, 2009, p. 14). This echoes a study by Aronson and Neysmith (1996) in which home care workers, describing the emotional component of their work as *non-work*, assumed the role of "ultimate responsibility", citing the fact that no one else was going to do it and therefore they often worked additional hours without pay (p. 70). The hidden dimension of a worker's resignation to being unpaid for overtime hours also connects with debates around the blurring of boundaries of informal and formal care work. As Benoit and Shumka emphasized, social and economic status "intersects with gender [as well as race, ethnicity, and migrant status] to constrain the opportunities and health status of women in this line of work" (p. 14).

In addition, the question of power and dependency are also well established in the relationships between care worker, caregiver, family members, and facility or agency management (Fine, 2005; Ungerson, 1997; Aronson & Neysmith, 1996). While it has been widely recognized that the vulnerable and dependent positions of care recipients expose them to the potential of an abuse of power by the care worker or caregiver, the reverse may also be true (Fine, p. 150). As Fine pointed out: "the charge may have power over the worker, as a result of social position, wealth, control of employment, or through worker's psychological (over)identification with the charge" (p. 150).

Studies of home care and facility-based health care workers reveal that overt exploitation can also take place through the adoption of the role of fictive kin, (a sociological term often applied to surrogate family members or friends), which is taken on by care workers in their relationship with care recipients (Karner, 1998; Dodson & Zincavage, 2007; Piercy, 2000). The "compassionate, family model" of care utilized by the long-term care facilities (for-profit and non-profit institutions) forms the structure of exploitation in the Dodson and Zincavage Massachusetts study. Health care workers in the long-term care facility are encouraged to form "authentic bonds" with residents, adopting residents as their surrogate parents (Dodson & Zincavage). This "family model of care" closely resembles the fictive kin relationships of Karner's home care workers. However, while the emphasis appears to be on compassionate care in a family-like environment, efficiency is in fact the bottom line. As Dodson and Zincavage pointed out, care workers are encouraged to form deep bonds and "adopt" residents in order to deliver a higher quality of care because "Without a doubt, the family model was good for business" (p. 915).

The exploitation of home care workers is integral to the blurring of boundaries between formal and informal care and to the growing marketization of care. In this article, I explore the roles and responsibilities that paid companions assume in their work, and the implications of paid companion service as a private care option in both home- and facility-based care situated in the context of these socio-political forces and issues.

Methods

Qualitative Methods and Theoretical Approach

Critical theory and political economy provided the theoretical principles that guided this analysis of the socio-political forces that have fuelled the development of paid companion service, including aspects of the employer/employee relationship of paid companion work connected to private agency employment. I also applied a phenomenological approach to gain an understanding of the meaning of companion service – and the motivations, experiences, and relationships of companions and clients – which were central to my inquiry. Three research questions were addressed:

1. What contextual circumstances (historical, economic, political, social) and personal situations have contributed to the use of paid companions?
2. What motivates companions to do paid companion work?
3. How do both paid companions and their clients experience their relationships with each other?

I utilized two qualitative methods of data collection – (a) semi-structured, open-ended, in-person interviews, and (b) autodriven photo elicitation – in order to examine the subjective experiences of paid companions and their care recipient clients/employers with an open and flexible approach. Autodriven photo elicitation was applied as the initial departure point for participant discussion, and this led to incorporating the semi-structured, open-ended questions into the interview process. Companions and clients began the interviews with a discussion of the photographs they had created – specifically for the interviews – that reflected their experiences as paid companions or clients.

The initial research questions were expanded to include more-specific interview questions in order to explore the experience of being a companion (or hiring a companion) and the relationship between paid companions and their clients. The interview questions follow.

1. Why did you become a paid companion? (Why did you hire a paid companion?) How long have you worked as a paid companion? (How long have you had a paid companion?)
2. What circumstances (personal, economic, social) contributed to your decision to become a paid companion? (What circumstances contributed to your decision to employ a paid companion?)
3. Could you please describe your duties as a paid companion? (Could you please describe your experience as the client/employer of a paid companion?) What kinds of things do you do for your client/employer? (What are your expectations of your paid companion?)
4. What is the nature of the interactions that take place between the paid companion and their employer? (Social exchange? Economic transaction?)
5. How would you describe your relationship with your clients/paid companion – good and bad aspects – (i.e., trust or mistrust; respect and appreciation or criticism; conflict or harmony)?
6. Is there an emotional component in your relationship with your clients/paid companion? If so, could you describe it please?

These questions were used as a guideline in the interview process and were often answered within the unstructured format of the photo elicitation component that began the interview. However, if the specific research questions were not discussed during the photo elicitation section, they were addressed later on in the interview. Field notes, made after each interview, supplemented the interview process.

I decided to combine the visual method of autodriven photo elicitation with semi-structured interviews because of photo elicitation's potential to expand the interview process and achieve a deeper level of understanding of participants' experiences and relationships. According to Harper (1998), when the research participant (or the individual pictured), "interprets the image, a dialogue is created in which the typical research roles are reversed. The researcher becomes a listener and one who encourages the dialogue to continue" (p. 35).

Autodriven photo elicitation takes the process one step further by providing another "voice" for the participants who have created the images that are then discussed in the interviews. Although not without its challenges, the visual nature of autodriven photo elicitation has many benefits. Primary among those benefits is the way that interviewing a person in conjunction with photographs of that person alters the interviewer–participant relationship. When control of the interview's initial stage shifts from interviewer to participant, allowing the participant to "tell their story" without interruption through discussion of their photos, a creative, personal space opens up, generating a three-way conversation involving the photograph, the researcher-interviewer, and the participant (Pink, 2003). In this context, the photographs operate as a mediating force, a "third party" in the conversation: the gaze of the interviewer shifts from the participant to the photograph, and in the process, the interview is transformed from an interviewer-subject relationship into a personal and collaborative experience between interviewer and participant (Pink). In addition, changing the locus of control from interviewer to participant slightly shifts the interview's power dynamic, creating a more neutral, malleable environment for both researcher and participant.

Sampling and Recruitment

The final set of data for this research was drawn from 30 qualitative interviews with paid companions ($n = 15$)

and care recipient clients ($n = 8$), plus ($n = 7$) key informants (up to saturation). The initial research design called for companion-client dyads, but this was expanded to include companions and clients not part of a specific dyad as it proved difficult to recruit both members of the dyad (there were only two companion-client dyads in this project). Reasons for this sort of difficulty vary, but first of all, clients of companions with dementia could not be included in the study and secondly, a lack of client or companion interest in participating in research was an obvious cause for exclusion.

To gain greater understanding of paid companion work from a historical perspective and within a private agency context, seven key respondents were added to the study's research design as a supplementary component. These consisted of five private home care agency representatives, one senior's asset management company owner/manager (who hired paid companions), and one retired volunteer coordinator (who provided a historical overview of the implementation of companion service in public facilities).

Non-random convenience and purposive sampling were used. Interviews were conducted between October 2009 and April 2010 in the Greater Victoria and Sidney areas of British Columbia and were accompanied by 142 participant photographs produced from the auto-driven photo elicitation component (102 companion photos and 40 client photos). Many more companion than client photographs were submitted because of the greater number of companions than clients and because some companions submitted more than the requested four-to-six photos per participant.

Recruitment began in September 2009. Participants were recruited using a number of strategies: list serves, posters, personal and professional contacts, private home care agency recruitment support, retirement home presentations, and snowball sampling. Paid companions who worked independently, as well as those employed by private home care agencies, were recruited. Research participation criteria for companions stipulated that companions had to work (or to have worked) with independent clients who lived at home, although they could additionally have facility-based clients. Elderly clients living independently in their own home (single-family residence, condo, townhouse, or apartment) or in a retirement residence qualified for participation.

Data Collection

Paid companions and their clients/employers were interviewed separately (recorded with an audio digital recorder), and the digital recordings were transcribed along with supplementary field notes recorded after each interview. In addition, interviews were conducted during this time with key respondents. Paid companion and client interviews were approximately 1.5 hours in length on average; key informant interviews ranged between 45 and 60 minutes in length. Prior to the paid companion and client interviews, participants were asked to create a small photo album of four to six photographs of people, places, objects, activities, or situations that they associated with the experience of being a paid companion or reflected the experience of having paid assistance and/or companionship. Single-use point-and-shoot cameras were provided to participants who did not have access to a digital camera.

Data Analysis

QSR's NVivo 8 computer software was utilized to help organize and code the data (interviews and photographs) by content and theme, many of which overlapped. NVivo allowed for a more thorough understanding of the themes that emerged from the research. In addition, I created a wall mural or *wall analysis* with the 142 participant photographs. Photographic and qualitative interview data were analyzed separately and together. The qualitative interview data were analyzed on an ongoing basis throughout the research process. Specific analytic steps for the interview data included these: (1) a descriptive summary of each interview; (2) thematic coding; and (3) dyadic analysis (of individual dyads, and compare-and-contrast of all companions and clients).

Results

Definition

It is difficult to define a paid companion in terms of the specific work and tasks performed. Nevertheless, two very different types of companions were clearly evident in this research: facility-based and home-based. The description of a facility-based companion was fairly straightforward: a person who provides a form of commodified friendship and care to individuals living in assisted living or LTC facilities[3]. They offer visiting and conversation, reading, outings and walks, music, art, respite, and palliative care. They provide no personal care with the exception of feeding assistance.

Defining home-based companions was more difficult. Although the job description of home-based paid companions is very similar to home support workers, the perception of the work varied greatly among companions. In general, however, a home-based companion can be defined as a person who provides care and home support to people living independently, either in their own home or in retirement facilities, but with an emphasis on the *relationship* with the client. Home-based companions provide a wide range of services: personal care, meal preparation, light housekeeping, laundry and ironing, transportation, gardening, pet care, and computer assistance, as well as respite and palliative care.

However, from the recruitment stage through data collection, ambivalence and divergence of opinion concerning the meaning of the term paid companion surfaced with both companions and clients. Eleven companion participants identified and advertised the work they did as companion service: paid companion (4 participants), companion (4 participants), companionship (2 participants), companioning (1 participant). The participants who chose companion, companioning, or companionship rather than "paid" companion emphasized that because friendship was a major component of the service they provided, acknowledging the economic component of the work by adding "paid" to *companion* diminished the job title and their relationships. However, companioning and companionship in this context were interchangeable and did not differ in definition.

Ambiguity was further reflected by the responses of the remaining four paid companion participants who labeled their work with other terms: trusted personal assistance provider, home support worker (but this individual planned to adopt the term paid companion for her future work), caregiver, and volunteer. Reasons for these different labels varied, but arose from questions of the interpretation of the job description; personal care and companionship; association of the term with unwanted professions such as escort service or sex work; and the commodification of friendship.

The question of personal care and companionship reflected the term's ambiguity, often arising in discussions of the job description of paid companions. While 13 companions assumed that personal care was simply part of the job description, two companions (who would not take on clients with personal-care needs) felt that when personal care was an element of the work, companions become home care workers or caregivers.

The issue of personal care was also reflected in the paid companion policies of private home care agencies. Agency representatives differentiated between home support work and paid companionship based on the specifics of their work. Facility-based workers, who provided social-emotional support to clients and provided no personal care with the exception of feeding assistance, were specifically designated as "companions." Yet agencies stressed that companionship was always a component of the task-based services provided by their other workers as well (i.e., home support, nurses, housekeeping). However, although companions often stated a preference for companionship over task-based work such as personal care, housekeeping, or meal preparation, agency representatives said that while they hired workers who were only willing to provide companionship (in private homes or facilities), these workers received many fewer hours of work (and usually received less pay per hour) than workers who were more flexible and willing to take on a variety of home care tasks for private home clients in addition to companionship. On the other hand, facility and independent work offered the "companion-relationship" work option for companions who could financially afford to work less.

Companions who work in this capacity fulfill a distinct role, providing older adult clients with social and emotional support that stands alone, outside of the task-based services provided by home support workers. And yet it should be emphasized that whether the job entailed only companionship (or was given in the context of providing personal care or task-based assistance), 11 of the companions who were interviewed identified the work that they performed as a type of companion service.

The same ambiguities surrounding personal care and companion service also arose with clients. Furthermore, the phrase "paid companion" had a negative connotation for clients connected to other issues including (a) a decreased status or class, (b) a lack of independence, or (c) an inaccurate depiction of the friendship-based relationship with the companion (which was the most common reason given). As a result, because many clients did not like the implied meaning of having a *paid* companion, they often preferred to use other terms – personal assistant, helper, senior's support, home care worker, caregiver, or friend. In addition, in two instances, a job title other than paid companion was used because that was the title supplied by either the agency or retirement home that had provided the worker.

Although there was no consensus among companions or clients around the use of the term *paid companion*, the following definition would appear to encompass both types of companion (home-based and facility-based). *Paid companion*: A person who offers a form of commodified care to individuals living in private homes and facilities. They provide a wide variety of supportive services that vary depending on the client and where the services are delivered. These services may include visiting and conversation; accompaniment on outings; transportation to and from appointments and shopping; light housekeeping and meal preparation; personal care; and respite and palliative care.

Description of the Paid Companion Sample

Paid companions interviewed for this research were between the ages of 40 and 72 (the majority were women in their 50s and 60s); 13 companions were female and two were male. With only two male companions in the study, gender comparisons could not be made with any accuracy. Twelve companions were Caucasian with a European background, one was French Canadian, one was Chinese Canadian, and one was Jewish. Although the cultural implications of the companions' ethnicity were not explored and represent a limitation of this study, it was noted that the Jewish companion provided care to a large number of clients from the same cultural background/religion, while also serving Caucasian clients. However, the Jewish client in this study was not part of the dyad and instead received care from a Caucasian companion (who was not interested in participating in the research). The other companions in this study provided care to a wide range of clients from different backgrounds, although clients were usually Caucasian (European descent).

Eight companions worked independently, four were agency-based companions, and three worked for agencies and also had independent clients. The length of time spent working as a companion ranged from 1 to 28 years (with an average of 8.8 years). All of the independent companions had long-term clients for whom they provided care (2–10 years in duration) often through the palliative care stage of their lives. Agency-based companions occasionally had long-term clients living in facilities, but more often had temporary short-term private-home clients (two weeks to a year in duration). Depending on the needs of the clients and the type of work performed (i.e., facility companionship, home-based assistance) the number of clients per companion varied from 1–5 clients at a time. Most companions worked an average of 15–20 hours per week, with only 5 out of the 15 working 24 or more hours per week. Companions with only one client worked from 5–8 hours per day (3–7 days per week), while the majority of companions worked an average of 3–4 hours per day (3–5 days per week), with 2–3 clients at any one time. However, the hours worked and number of clients served varied greatly among companions, depending on the availability of clients combined with the limits companions placed on the number of clients they wished to take on at one time and hours available to work.

Although my research focused on companions working with independent clients living in their own homes, all but one of the companions also worked in facilities, most often with people with dementia. Companions were hired by families to provide support for a family member living in a facility, but also for family members with dementia who were living at home. These companions spent one to two hours with their clients on each visit, usually seeing clients two to five times per week. Without adequately funded public health care, the numbers of companions working with clients with dementia will undoubtedly increase as the number of seniors affected by the disease grows.

The educational backgrounds and employment experiences of paid companions varied but included (a) volunteer companion work; (b) home support work experience or Resident Care Attendant or Registered Nurse certification; (c) complementary medicine or a lay counselling background; (d) Early Childhood Education certification; (e) arts training; and (f) personal caregiving experience. Employed companions found work directly through home care agencies, whereas independent companions advertised their services in care facilities, local classified advertisements, caregiver organizations, and through word of mouth.

Companions and clients came from a range of social class and socioeconomic backgrounds, and although money formed the basis of the exchange, clients were usually, but not always, in a higher socioeconomic level than companions. For example, one client pointed out that her companion lived in a million-dollar home, while she could only afford to live in an apartment. While the majority of the paid companions described performing the work out of financial necessity, private home care agency wages for paid companions were quite low. Paid companions and their clients confirmed that in 2010, salaries for paid companions working for private home care agencies ranged from $11.50–$16 (average of $13 per hour), while independent companion wages were somewhat higher at $15 to $30 per hour (average hourly rate of $20 per hour).

According to key informants and paid companions, the number of paid companions has greatly increased over the past 10 years. Conversations with agency administrators put the number of paid companions working in Victoria in the hundreds, with at least that many more working independently, the majority on a part-time basis. Providing exact statistics for companion services within private home care agencies is further complicated because many agencies provide a wide variety of services ranging from companionship, housekeeping, and meal preparation to personal and palliative care. However, because the categories and duties of home care workers overlap, companionship is often integrated into the work performed by all of the categories of workers.

Description of the Client Sample

Clients ranged in age from 62 to 96 years (with an average age of 82); six females and two males were interviewed. In terms of ethnicity, six clients had a European background, one was Jewish, and one was Caucasian with a West Indian background. Four clients hired agency companions, and three hired independent companions (although one of those companions had both agency and independent client contracts).

As all of the client participants in this research were independent, companions were hired directly by the client, either through a private agency, recommendations from their retirement homes, or by word of mouth from friends and relatives. Clients' main reasons for hiring a companion included physical health difficulties combined with a desire to remain in their own home, although the social-emotional relationship they developed with their companions became equally important over time. The length of time clients had been with paid companions varied from two weeks to seven years; hours of service ranged from two hours to 70 hours per week (2–7 days per week).

Motivation for the Work: Financial Necessity and Emotional Rewards

Although financial necessity provided the original motivation for the majority of companions (9 out of 15), an underlying and deeper reason for pursuing (and continuing) this particular kind of work derived from an emotional and/or spiritual need to find connection and meaning in the work they do. Companions find this meaning in the rewarding relationships they developed with their clients in the process of providing companionship and care.

Initially, the majority of companions (60%) described entering the profession out of financial necessity: the need to provide for themselves and/or their children due to the death or divorce of a spouse; a job change requirement based on health concerns; a layoff from previous employment; or retirement in which additional income was necessary. Note that for independent companions, the salary could be quite reasonable if they were able to arrange a full-time work schedule, but the present data suggest that part-time work was usually the norm even for independent companions. For example, of the eight independent companions and the three independent companions who also did agency work, only three worked 30 hours or more per week. As a result, many companions reported that they found it necessary to have a second job to supplement their paid companion work (such as reflexology, lay counselling, art, or graphic design contracts). Another financial dimension appeared to provide a motivation for paid companion work: specifically the business opportunity afforded by companion work, which was the primary motivating element mentioned by two companions describing why they first began working in the profession.

On the other hand, four companions explicitly stated that money or business opportunities were not initial motivating factors. One paid companion who was financially secure emphasized that he did the work solely to feel useful and to "contribute to society". This same companion referred to himself as a "volunteer" rather than as a paid companion. His explanation for this distinction suggests an issue of class rather than gender: "I just consider myself a volunteer because I don't need the money. I don't have to do the work."

Three other companions left more-lucrative paid employment to work as a companion. For instance, the second male companion in the study became a companion to pursue work that offered emotional rewards not found in his previous professional employment. But in contrast to the first male companion who was retired and financially secure, the income generated from companion service was essential to the second male companion. His motivation to pursue this particular line of work, however, arose from emotional rather than financial need:

> So the foundation of why I'm doing this is because it makes me feel good, you know. At my age, [56] when I started to do that [work as a companion] it was not just trying to find another job, it was trying to find something meaningful and that made me feel good.

Another participant who started her paid companion career 25 years earlier emphasized that she had remained in the profession for so many years because of the satisfaction the work brought her, a sentiment also expressed by other companions interviewed for this research. For another companion, even though health problems began a chain reaction leading to employment as a paid companion, she continues with the work today because of the fulfillment she finds helping her elderly clients.

Friendship and Fictive Kin

During the interviews, all but two of the paid companions commented on the fictive kin aspect of their relationship with clients, describing their clients as friends or "like a mother, father, or sister." Eight out of 15 companions and seven out of eight clients referred to their relationship as a "friendship" or as a familial (fictive kin) type of attachment.

This companion-client connection of fictive kin finds parallels in the literature on home care workers and resident care aides who often become surrogate family members or friends to their clients (Piercy, 2000; Karner, 1998). Companions and clients described a process in which they became friends or fictive kin which was similar to Karner's (1998) three-stage process wherein American home care workers were transformed from care workers, who perform task-based duties, into trusted friends. A number of companions described the development of their relationship with their clients similarly. One companion explained the development of her father-daughter relationship with her client this way:

> Every client I've ever looked after – you go in it with a feeling of okay, this is a job. This is professional. But you can't help but bond with the person. You're there day after day, hour after hour through the day. They tell you things they wouldn't even tell their family. They rely on you for everything and me, too, for them. Because my clients have all been older and wiser, been through life, raised kids – they can give me advice and suggestions that I appreciate, and yeah, I have bonded with him. He's like a second dad in a way, you know.

It should also be noted, however, that a content analysis of participants' photographs revealed contradictions in the feelings and relationships of clients and companions. Of the total of 142 photographs, companions produced 102 photographs while clients produced 40. Forty-two of the total 142 photographs (30%) were photos of clients or companions, including 39 photos (27%) of clients but only 3 photos (1%) of companions. In addition, 17 of the 142 photos (12%) were photos of clients and companions together: 14 of these were taken by companions; only 3 were taken by clients. The majority of client photos focused on aspects of their personal lives: themselves (27.5%), family and friends (27.5%), housekeeping tasks that were done by their companions (20%), and home gardens from an earlier time in their lives (10%). Thus, clients and their lives were the focus for both companions and clients, raising questions about the employee-employer-friend relationship between them. Companions, who place a high value on the emotional satisfaction they derive from their work, may overlook the boundaries and limitations that are present in relationships with their clients.

It could be argued that companions' attitudes towards their work reflect Zelizer's (2005) *connected lives* theory whereby workers in many caring professions sometimes become friends with the people they work with or for. On the other hand, the fact that companions continue to work for low agency wages can also be interpreted within the *prisoner of love* hypothesis in which care is provided out of love, not money (England, 2005). In this framework, paid companions are reacting to their working conditions similarly to the response of the health care workers in the Dodson and Zincavage (2007) study who stayed in the job despite their low wages because they valued the relationships they had developed with residents. At the same time, the *devaluation thesis* (England) provides a framework that emphasizes the gendered and cultural biases that affect wages and government support.

A question of power is also implied in the content analysis. As employers, clients have the power in the companion-client relationship, which exposes companions to the possibilities of exploitation. Six clients also emphasized the importance of mutual respect, stating that as the employer, they expect to receive kindness, honesty, non-judgmental reactions, and a good quality of care from their companions. In return, they described showing respect and appreciation for their companions. And aware of the power they have over the relationship, most clients appear to try their best not to misuse their position with their companions. For example, one client who referred to her paid companion as a friend also acknowledged that there were self-imposed boundaries on the friendship:

> [Although I consider her a friend] I don't think that implies that you can make calls on her time outside of the hours she's paid for. But it's a pretty woolly border. For instance, we have our groceries delivered by Thrifty's and last week they sent us something that was hopelessly wrong, not what we wanted at all, and N. just said, "Oh well, I'm going to do my shopping on Saturday and I'll take this back for you and exchange it." And you say, "Oh, thank you so much." So in that sense she's a friend, but it's at her initiative. I would never ask her to do anything like that.

However, the question of friendship-work boundaries can become quite murky in other ways. Describing her companion as a "friend", another client discussed the complications that arise from a friendship-based relationship with her companion when the boundaries of paid time are transgressed:

> Because I am now so enmeshed in her life that, not infrequently – sometimes more than others and especially depending on what's going on in her life – a lot of our time together might be spent sitting and talking about her "stuff," which I don't really like. I wouldn't mind if it wasn't on the clock. You know I'd be happy to do it, but it does trouble me when we might sit talking for an hour about her stuff, which I am then paying her [money] for. I wouldn't even mind if I got short-changed the hour and only paid for the two hours she worked.

Nevertheless, the companion-client relationship was characterized as important by almost all of the research participants (13 companions and 8 clients) in the qualitative interviews, although both clients and companions emphasized that the relationship did not develop instantly and not with everyone. Trust and confidentiality, essential to building any relationship, were described as major issues for clients and requiring time to achieve.

Companionship as a Commodity

Ambiguity, however, is embedded in the economic aspect of the work. As mentioned earlier, the inclusion of "paid" in the title of paid companion was an issue for some clients and paid companions, diminishing the job title and relationships with clients. Two companions stated that they wished that they could afford to do the work without pay. One paid companion stated: "I never did like the words *paid companion* because I just wanted to do it for free and just felt that the service should be done for free." The other companion planned to become a volunteer companion when she retired, while a third companion (the retired paid companion in the study) had provided volunteer companionship when she retired as a paid companion.

Boundaries imposed by private agencies on their workers reflect a discrepancy in the literature in terms of paid companion work in Victoria. U.S. studies (e.g., Karner, 1998) have revealed that the organization tried to place boundaries on the relationships between facility staff and care recipients – specifically discouraging emotional connection and attachment which takes place through the "sharing of selves" between the care worker and the care recipients (p. 9).

However, companions who work for home care agencies in Victoria generally experience a different perspective. Because the agencies do their best to maintain consistency of staff with their clients, the relationship between client and companion is encouraged. Although most agency representatives said that while the task-based component of the work is a necessity for clients striving to maintain their independence at home, the worker-client relationship is integral to the work. In discussing the emotional-social aspect of the relationship between workers and clients, one agency representative stated: "It is very, very important. It's what we're all about." Another agency spokesperson put it this way: "The human aspect of care is the very most important thing. What else is there?" However, like their American counterparts, Victoria's private home care agencies are operating within the private sector of health care where profit is the number-one priority.

A focus on profit for private home care agencies also translates into lower wages for workers. The American home care and facility-based health care workers in the Dodson and Zincavage (2007) and Karner (1998) studies all complained of low wages, long hours, and understaffed facilities. Agency-based paid companions in my research voiced the same criticism: wages were too low. While companions in Victoria appreciate the job flexibility, legal protection, and pre-arranged clients that agency work provides, seven out of the eight companions who worked for agencies commented on the low pay (and the one who did not emphasized during the interview that wages received for companion work were not a necessity; there were other motivations for doing the work). Even though one companion discovered that the agency she worked for had not been paying her fair wages, her response was that "the money was a bonus" as she did the work because she enjoyed it.

Providing unpaid additional services to clients is linked to the nature of the job and client expectations, also reflecting the literature on the exploitation of home care workers in the United States and Canada, and the literature on the concept of non-work (Aronson & Neysmith, 1996). Operating within the framework of obligation and responsibility, seven companions mentioned doing extra errands for their clients outside of their paid hours: shopping, dog sitting, picking up a prescription, or staying a little longer past their paid hours to finish up a task for the client. Their reasons for putting in extra unpaid hours included "a sense of responsibility for the client" or the fact that there was no one else available to do it, once again echoing studies on home care and facility-based workers (Dodson & Zincavage, 2007; Karner, 1998). While it is unclear if private home care agencies in Victoria encouraged their employee companions to engage in this extracurricular activity, were unaware of it, or simply looked the other way, it nevertheless took place.

The perception of companion work as non-work was discussed in another context by companions. Paid companions experience disapproval and bias because of an interpretation of their work by some people as sex work, but also in its association by others as non-essential – that is, non-work. This kind of perception rejects the validity of companion service, a situation that finds parallels in the "invisible" work performed by ancillary health care workers (Aronson & Neysmith, 1996). Although interactions with facility staff were usually positive, three companions mentioned experiencing hostility from facility staff on a number of occasions. One companion described a very unpleasant encounter with a nurse in a hospital facility which took place in front of the family member who had hired her to provide respite companionship for her mother:

> So I met with her, and she introduced me to her mum and then this little nurse walked around the corner. She [the daughter] introduced me and said, "This is S., she is a companion and is going to spend some time with my mum so that I can go home and get some sleep." And the nurse said, "What are you going to do? Are you going to clean her? Are you going to feed her? Are you going to do this?" I said, "Well, no. I'm actually just going to sit with her and speak to her and just keep her calm, so she doesn't get agitated and scream out. There are four people in this unit." And she turned to the daughter and do you know what she said? "You are wasting your money."

Facility-based Companion Service

Paid companions also fill a unique role in care facilities. In this environment, the relationship-focused work of facility-based paid companions appears quite unlike that of home-based paid companions, home care workers, or facility care aides. Note, however, that facility-based companions are providing the emotional and social support previously assumed by facility health care workers. Private home care agency administrators emphasized that as a result of the cutbacks to staffing ratios that took place over the past 10 years in British Columbia, the services of paid companions have become more in demand in –Public-Private Partnership facilities by families seeking support for their elderly family members with dementia. Health care facility workers now have limited time and are unable to provide little more than the basics of personal (physical) care for residents. Indirectly acknowledging the effects of neoliberal policy on public health care, one private home care administrator explained the reasons for family requests for companion service this way:

> The most common thing I would say is that if they [family members] are in a facility, that usually the facilities with all the cutbacks are just not able to provide the personal level of care people need. We had one [family request] where they wanted someone to take their mum to the Rec Room so she could be involved, because the people in the facility were so busy that if their mum was too slow getting out of bed, they would move on to the next person. So she would miss out on stuff. So I think a lot of it is to try to overlap, to try and cover the deficiency these cutbacks and things are having on their parents.

Three of the five private home care agency representatives who were interviewed stated that the majority (75%) of service requests come from families from across Canada for their parents who are in LTC, assisted living, or retirement homes. In all five agencies, the main reason families sought assistance was due to dementia; companion service was requested either directly for the family member with dementia or for respite for a family caregiver. For families with adequate financial resources, paid companions now fill this care gap, providing social and emotional connection for their elderly clients living in facilities.

Companions offer many ways for their clients to engage with the world through visiting and conversation; transportation to and from appointments; accompaniment on walks, swimming, and other outings; assistance with feeding; respite and palliative care; and creating opportunities for their elderly clients to "be in the world". Although feeding assistance is in fact a type of personal care, it has been allowed since the 1970s, most likely because of the time-consuming nature of that assistance and the limited number of staff available to perform that task.

Importantly, virtually no research has been conducted on this aspect of paid companion work aside from my own exploration of companion service, which indirectly documented companions working in care facilities. Further research needs to be done on this area of companion service.

Socio-political Implications

Although the research questions did not specifically ask participants to comment on the socio-political implications of paid companioning, there was a noticeable lack of awareness with respect to the position of private paid companion work within the public health care system. When the question of the inequity involved in their work came up during the interviews, companions acknowledged that the service was only available to a select group of people with the financial resources that would allow them to pay for companionship. However, only two companions addressed this issue in any depth. One companion described her feelings about it this way:

> But, unfortunately, it's the people that really have the money [who can hire companions]. I remember years ago, though, one of my clients had very little money, and I was still a companion to him for a long time for much less than the others were paying. But I just wanted to do that. And because it's my business I can do whatever I want. You know, I can charge or not charge.

The majority of paid companions failed to comment on the implications of working in a private home care service that was functioning within the public health system. Only one companion raised the issue of a deteriorating public health care system. Instead, most of the companions focused on the nature of their work and the relationships they developed with their clients. Criticisms of companion service were few, and what criticism arose was not directed at the general underlying political structure or even governmental policies, but more specifically at the low wages paid by private home care agencies. Some companions also mentioned the lack of benefits,[4] sick leaves, and job security available to those working for private agencies. But, although better paid, independent companions also lacked benefits or job security due to the private contractual nature of their work.

Clients' focus was on having access to a service that allowed them to remain in their homes, and out of assisted living or LTC facilities. They were not concerned that it was a private care option. They were, on the other hand, concerned with the high cost of hiring a companion through an agency, as well as the low wages that companions received from agencies.

The apparent lack of a critical perspective by participants suggests an internalizing of the ideology of *responsibilization* (Rose, 1996), one of the tenets of neoliberalism, whereby individuals assume total personal responsibility for services that were previously provided by the state. And as neoliberalism has slid into the realm of economic determinism and hegemony, its socioeconomic policies and ideology have been obscured and thereby rendered invisible (Navarro, 2002). However, one companion indirectly remarked on the commodification of care that was taking place with these comments:

> How can [companionship] not be as essential as breathing? Because, really, it's a reflection of our cultural times that families are spread apart, that we're all working so much to live in this supposedly technologically easier culture, but it takes all of our time. And so, the cost of living – both people working – it's not like you live in an extended family anymore. So it's caring to bring people in. Now it's paid, that's all – it's not extended family: everything is paid.

Discussion and Conclusion

This study is one of the first to examine the work and experiences of paid companions in Canada. With the restructuring of Canadian health care over the past three decades, responsibility for care of the elderly has increasingly shifted from government services to community and family caregivers (Baines et al., 1998; Penning et al., 2006). The governments of North America and Western Europe are replacing formal, institutional care with community care (from hospitals to cheaper providers who are often unpaid family caregivers and paid workers in care facilities). In the process, community or home care is promoted as *choice,* when in reality it is just a cost-cutting method of government to shift care back to the family (usually to women). Dominant policy discourse on LTC practices emphasizes the practical aspect of LTC work which is seen as "real" work (task oriented), while relational labour is ignored, and in this way, government policy easily exploits workers (Aronson & Neysmith, 1996).

As a result of government cutbacks to home and LTC, some seniors and their families have sought other means of care and support – paid companions reflect one of these new private care options. For older adults living in their own homes and in retirement homes who can afford to pay for private care and support, paid companions now perform a wide range of services. But the increasing use of private home care services contributes to a deepening of the health care divide, providing a range of services for older persons with high incomes but offering very limited support options to those with low incomes.

The growing utilization of paid companion services in assisted living and LTC facilities care further strengthens this inequitable division of care. Filling the void in care left by government staffing ratio cutbacks of the past 10 years, companions provide private care (i.e., emotional and social support, as well as feeding assistance) within public facilities. Because health facility workers' time is now greatly rationed and focused on personal care only, for families with adequate financial resources, paid companions now fill this care gap by providing companionship and connection for elderly residents, keeping them involved and engaged, while residents from low-income families unable to afford additional, privately paid personal assistance receive only the basics of physical care. At the same time, the increasing use of companions in care facilities by those with high incomes enables governments to implement additional cuts to health care services which further reduces levels of care and support for the general population.

Uncertain political economic times will undoubtedly have an impact on Canadian neoliberal health care policies in the future. But it is highly unlikely that the commodification of aging and the biomedicalization of health will decrease as long as neoliberalism remains the foundational structure of our political system. The consequences for paid companion service will reflect global and national economic conditions and policies. If neoliberalism should fall out of favour and the state is replaced with governments that decide to reinvest in home care, what will the fate of companion service be?

In that case, in addition to a reinstatement of government-funded home care that could be made available on an equitable basis for home support such as housekeeping and meal preparation (Chappell & Penning, 2005), regulated companion services could also be provided, enabling many more seniors to remain in their homes and reducing health care costs overall. And if governments were to increase rather than decrease funding to LTC, companion services would be in less demand, with health care workers once again able to provide emotional and social support to facility residents in addition to personal care. This scenario, unfortunately, is extremely improbable. Instead, government cutbacks will most probably continue in health care resulting in the increased use of companion services among the financially secure elderly, remaining an exclusive private care option available only to the few.

Notes

[1] *Autodriven* is the term given to this method of photo elicitation in visual studies (Samuels in Stanczak, 2007, p. 196). This method has also been referred to as *photo voice* in sociological research with an emphasis on participant photography as a tool for community development and social action (Wang & Burris, 1997).

[2] With roots in the early 19th century, *familialism* is an ideology that privileges the family as opposed to the individual, thereby making the assumption that the family will sustain the primary responsibility for the care of kin family members (Leitner, 2003).

[3] Although the companions that I interviewed stated that the majority of their clients were older adults, they also work with younger clients who have various debilitating, life-limiting chronic conditions such as multiple sclerosis and brain injuries (in facilities and at in their own homes). The additional care of these individuals, which covers the services of paid companions, is often paid for through publicly subsidized funding (e.g., the Public Guardian and Trustee of BC), which is not available for elderly clients with dementia.

[4] Of the five agencies represented in this research, only one provided any benefits. They offered medical and dental benefits to workers who had been with the agency a minimum of 6 months and who worked at least 20 hours per week.

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