Economic Impact of Health, Income Security and Labour Policies on Informal Caregivers of Frail Seniors

by

Janet Fast, Jacquie Eales and Norah Keating

Department of Human Ecology, University of Alberta

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Translation Quality Control: France Boissonneault

For more information contact:
Research Directorate
Status of Women Canada
123 Slater Street, 10th Floor
Ottawa, Ontario K1P 1H9
Telephone: (613) 995-7835
Facsimile: (613) 957-3359
TDD: (613) 996-1322
E-mail: research@swc-cfc.gc.ca

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PREFACE

Good public policy depends on good policy research. In recognition of this, Status of Women Canada instituted the Policy Research Fund in 1996. It supports independent policy research on issues linked to the public policy agenda and in need of gender-based analysis. Our objective is to enhance public debate on gender equality issues, and to enable individuals, organizations, policy makers and policy analysts to participate more effectively in the development of policy.

The focus of the research may be on long-term, emerging policy issues or short-term, urgent policy issues that require an analysis of their gender implications. Funding is awarded through an open, competitive call for proposals. A non-governmental, external committee plays a key role in identifying policy research priorities, selecting research proposals for funding and evaluating the final reports.

This policy research paper was proposed and developed under a call for proposals in August 1997 on *reducing women's poverty: policy options, directions and frameworks*. Status of Women Canada funded nine research projects on this issue. These projects range from very broad analyses to more focussed studies.

Some of the broad areas of policy research undertaken through this call for proposals examine the dynamics of poverty, links between social policy and gender inequality, and frameworks and policy options for reducing women's poverty. Some of the more specific research questions look at links between housing and employment, hidden costs of elder care, effects of home care, pay equity in Quebec, the relationship between women and the state in Quebec, and retirement incomes. A complete list of the research projects funded under this call for proposals is included at the end of this report.

We thank all the researchers for their contribution to the public policy debate.

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EXECUTIVE SUMMARY

The extent and consequences of elder care are well documented. However, little is known about how individual policies actually influence the economic well-being of informal caregivers or about their collective effect across policy domains and jurisdictions. The first objective of this project was to analyze the economic impact of current health, income security and labour programs by type of informal caregiver, and region of the country. The second objective was to develop a policy analysis framework to facilitate ongoing evaluation of the impact of any policy instrument on the economic costs to informal caregivers of frail seniors.

There were several steps in meeting these objectives. We first determined the economic costs informal caregivers may experience because of their elder-care responsibilities. These may include lost current and future income, lost employment benefits and out-of-pocket expenditures, in addition to their unpaid labour. Second, we chose three regions for subsequent comparative analysis: the Capital Regional District of British Columbia, the Niagara Region of Ontario and rural Cape Breton in Nova Scotia. Third, we developed profiles of different types of informal caregivers based on analysis of Statistics Canada's 1996 General Social Survey and 1996 Census, and consultation with stakeholders. The three types of informal caregivers (with a female and male profile for each type) that emerged from this process were adult children with young children of their own, adult children without dependent children and who are primary caregivers, and spouse caregivers. Federal, provincial and regional policies and programs in place as of June 30, 2000, across the domains of health, income security and labour, were reviewed. These profiles were then used, as case studies, for comparative analyses (by caregiver type and region) to determine how policies affect informal caregivers' economic status. Through this process, the characteristics of caregivers, care receivers, regions and policies that made a difference to the economic well-being of informal caregivers, and those that did not, became apparent.

These key characteristics were used in creating the policy analysis framework, a template for analyzing the economic impact of a given policy on informal caregivers of frail seniors. There are four components to the framework. The policy instrument or program and its eligibility criteria determine whether informal caregivers or their care receivers qualify. If eligibility criteria are satisfied, then certain characteristics of the caregiver, care receiver or region may moderate the economic impact of the policy. These key characteristics include the presence of young children, labour force status, geographic proximity, care receiver's income and regional economy. Gender of the caregiver is also an important consideration as women compared to men are differentially affected by (or incur greater costs because of) their elder-care responsibilities. Finally, the framework identifies the types of economic costs caregivers may experience: lost current and future income, lost employment benefits, out-of-pocket expenses and unpaid labour. The framework illustrates the variance in the relationship between a given program and types of economic costs incurred, depending on the moderating characteristics, the gender of the caregiver and the interactions between these variables.

In applying the framework to the policy instruments reviewed, we found that most programs have the potential to impact informal caregivers' out-of-pocket costs, particularly in

circumstances where care receivers are unable to afford services. User fees and low ceilings on means tests make services less affordable to low-income seniors with the result that they are more likely to require the financial assistance of family and friends. While employment-related costs are the least likely to be addressed by existing policies, they have the greatest potential impact on informal caregivers' costs. The relative paucity of leaves of absence, because of family responsibility, in employment standards across Canada and current conditions of the Canada Pension Plan affect the current and future incomes of informal caregivers. The extent to which direct labour costs are affected by policies is unclear. Available evidence suggests that the provision of formal services does not cause informal caregivers to reduce their unpaid labour. Rather, informal caregivers are more likely to sustain their involvement longer with support from the formal sector. What is unknown is whether the involvement of informal caregivers increases when formal services are reduced or withdrawn.

The presence or absence of programs and services may affect the economic status of informal caregivers. Caregivers living in poor or isolated regions are disadvantaged by the lack of programs and services. When programs and services do exist, the magnitude of their economic impact is moderated by characteristics of informal caregivers, care receivers or the regions in which they live. Surprisingly, some programs provided little economic benefit to informal caregivers. This was true even with programs that targeted informal caregivers, such as the caregiver tax credit. In some cases, this can be attributed to an incongruity between program eligibility criteria and the characteristics that strongly predict economic consequences for informal caregivers.

In sum, informal caregivers who are least well-served by existing policy instruments are women who are employed, who have concurrent child-care responsibilities and who live at a moderate distance from their care receiver. Non-kin caregivers are especially poorly served. Poverty of the care receiver is a double-edged sword: poor seniors, and those caring for them, are more likely to be eligible for benefits, but they also are less able to cover the costs of caring for themselves. Policy recommendations are offered to address these issues and reduce the economic impact of policies on informal caregivers of frail seniors.

1. INTRODUCTION

It has been estimated that informal caregivers provide as much as 80 percent of all the care needed by frail seniors (Finch 1986; Parker 1990; Rankin 1990; Stone 1991). An aging population, advances in medical technology, and reform in the health and continuing care policy sectors are further increasing the demand for informal care (Fast and Keating 2000). In particular, concern over public cost containment is prompting policy reforms that further shift responsibility for care from the formal to the informal sector (Keating et al. 1997). At the same time (perhaps in an effort to make this shift feasible), there is much discussion among policy makers and practitioners about the need to support informal caregivers in their work.

There is growing evidence that family and friends care for seniors willingly and with dedication, but that they do so at great cost (Keating et al. 1999). The same demographic, social and policy trends that are increasing the workload of informal caregivers also can be expected to increase their costs. Thus, cost containment becomes as critical in the sustainability of the informal care sector as it is in the public sector.

It is increasingly apparent that a wide range of policies has the potential to affect consequences experienced by informal caregivers. Responsibility for the array of policies that might affect caregivers' costs is split among federal, provincial and local governments. As a result, costs are likely experienced differentially by caregivers in different parts of the country. Canada's geographic, climatic, economic and social diversity also make geographic variation in the impact of policies likely.

Great diversity among caregivers may further contribute to variation in how policies affect the experiences of individual caregivers. In particular, marked gender differences in involvement in, and the consequences of, caring for senior friends and relatives have been observed (Fast and DaPont 1997; Gignac et al. 1996; Keating et al. 1999; Penrod et al. 1995). This makes gender-based analysis of the implications of public policies for informal caregivers essential. Gender-based analysis "makes it possible for policy to be undertaken with an appreciation of gender differences, of the nature of relationships between women and men and of their different social realities, life expectations and economic circumstances" (SWC 1996: 4).

While the *potential* for policies to affect the consequences of informal caregiving is now recognized, little is *known* about how individual policies actually influence caregivers' costs. Even less is known about the collective effect of the complex maze of interrelated policies and policy instruments that exist in Canada. In part, this is the result of a lack of any systematic mechanism for evaluating how policies might affect the type and magnitude of consequences experienced by informal caregivers. It is also due to the dynamic nature of the policy environment. We hope the results of this project undertaken for Status of Women Canada will help remedy these deficiencies. In this report, we present the results of our evaluation of the potential for policies to moderate or exacerbate the economic consequences experienced by informal caregivers and describe a framework that can be used by practitioners and policy makers to assess that potential on an ongoing basis.

Objectives

There are two objectives of this research project.

- Analyze the economic impact of current health, income security and labour policies by region, type of informal caregiver and gender.
- Develop a framework that can be used to evaluate the impact of national, provincial and regional policies on the economic costs to informal caregivers of frail seniors.

Terms of Reference

We begin by establishing a common understanding of terms frequently used in this document.

- *Economic costs* involve money or money equivalents, and affect standard of living, such as employment-related costs, out-of-pocket expenditures and unpaid labour (Fast et al. 1999b). In comparison, *non-economic costs* result from declines in certain aspects of quality of life: physical, social and emotional well-being (Fast et al. 1999b).
- *Informal caregivers* refer to family members, friends and neighbours who provide assistance to a senior because of that senior's long-term health or physical limitation, based on a personal history between the individual who helps and the individual who receives help (Keating et al. 1999; NACA 1990). The term "informal" does not reflect the commitment to caring or the way in which care is provided.
- *Policy instrument* refers to "the technical means of achieving a [policy] goal" (Pal 1997: 102). For example, spending, regulation, exhortation or taxation may be ways to achieve policy objectives (Pal 1997). Policy instruments examined in this project include legislative acts, regulations, program documentation and written service delivery procedures that are mandated or administrated by a government body as of June 30, 2000.
- *Region* refers to a specific area of Canada having more or less definitely marked geographic boundaries and characteristics.

The remainder of this report describes the process used, and results obtained, in pursuing the objectives stated above. In Chapter 2, we describe the data that informed our policy analysis. These include the economic costs family and friends may experience when taking on caregiving roles, the regions of the country chosen for comparative analysis of caregivers' situations under different policy regimes, the profiles of representative caregivers used as case studies and a description of the policy environment. In Chapter 3, we report the results of our analysis of the potential for variations in policy regimes to affect the consequences experienced by informal caregivers, as mediated by caregiver, care receiver and caregiver–care receiver dyad characteristics. This chapter concludes with a description of a framework that can be used by policy makers, practitioners and researchers to determine the impact of any given policy on any given caregiver. In the final chapter, we draw conclusions from our policy impact analysis on the ways in which the policies examined likely affect the economic consequences experienced by the informal caregivers profiled in our case studies. We close with a set of policy recommendations that flow from these conclusions.

2. BACKGROUND INFORMATION ON ECONOMIC COSTS, REGIONS OF CANADA, CAREGIVER PROFILES AND POLICY SCAN

The first objective of the project was to analyze the economic impact on informal caregivers of current health, income security and labour policies by region of the country, and type of caregiver. This involved several steps. First, we determined the set of economic costs. Second, we chose regions of the country for subsequent comparative analysis. Third, we developed profiles of different types of informal caregivers and, fourth, we scanned current health, income security and labour policies. Finally, we conducted comparative analyses, by caregiver type and region, to determine how policies affect informal caregivers.

Economic Costs

Defining the set of economic costs informal caregivers may incur was important for two reasons: it focussed our scan of public policy instruments that may have a direct or indirect economic impact on informal caregivers, and the set of economic costs formed one component of the policy analysis framework.

Fast et al. (1999b) proposed a taxonomy of the hidden costs of informal elder care by stakeholder group. Stakeholder groups were care receivers, caregivers, caregivers' families, caregivers' employers and society at large. We focussed on those costs that informal caregivers may incur because of their elder-care responsibilities. They were broadly categorized as economic and non-economic costs.

Economic costs involve money or money equivalents and affect standard of living. In comparison, non-economic costs result from declines in certain aspects of quality of life, such as physical, social and emotional well-being. While these latter costs are important, our focus was on the economic costs that may affect informal caregivers, because these are the costs often used as the basis for policy action. Economic costs are differentiated into employment-related costs, out-of-pocket costs and unpaid labour (Fast et al. 1999b).

Employment-Related Costs

Over 70 percent of men (70.5 percent) and almost half of women (46.8 percent) caregivers are employed full time (Keating et al. 1999). When caregiving responsibilities interfere with caregivers' employment, economic costs may be incurred. Employment-related costs include lost current and future income, and lost employment-related benefits. Caregivers may take unscheduled days off, arrive late to work, leave work early or take extended breaks to deal with elder-care responsibilities. Some employees may lose pay when adjusting their work schedules to accommodate their elder-care responsibilities (Barr et al. 1992; Scharlach and Boyd 1989). Current income may also be foregone when caregivers decrease hours of paid work, turn down overtime hours or leave paid employment to provide elder care. Reductions in hours of paid employment or withdrawal from the labour force may also result in foregone employment-related benefits (Glendinning 1992), such as extended health care insurance and future pension benefits, including both employer-provided pensions and Canada/Quebec Pension Plan (C/QPP) benefits. Finally, future income may be lost when caregiving responsibilities hinder the acceptance of career-related opportunities, such as

additional training, attending conferences, extra projects and promotions, which often lead to salary increases.

Out-of-Pocket Costs

These expenditures would not have occurred had informal care not been provided. These additional, out-of-pocket expenses can be categorized into four groups (Glendinning 1992; Netten 1994; Weinberger et al. 1993). First, informal caregivers may purchase goods for the senior to whom they are providing care. Second, caregivers' expenditures for heating, food, laundry and transportation may increase when seniors live in caregivers' homes. Third, some informal caregivers incur costs for services to the senior, such as respite care or home alterations that would make the living space more accessible. Fourth, caregivers may "buy time" to look after the care receiver by purchasing services such as child care, housework and yard work for themselves. These out-of-pocket costs have a direct impact on their disposable income.

Unpaid Labour

Unpaid labour refers to the unpaid work provided by informal caregivers to care receivers which, increasingly, is acknowledged as productive and economically valuable (Waring 1988). The value of the unpaid work performed by informal caregivers is a major component of the hidden costs of informal elder care. A recent study estimated the replacement value of the 2.1 million unpaid informal caregivers in Canada to be more than $5 billion a year (Fast and Frederick 1999).

In summary, the typology of the hidden costs of elder care (Fast et al. 1999b) led us to use five types of economic costs in our project: lost current income, lost future income, lost employment-related benefits, out-of-pocket expenses and unpaid labour. These costs are used later to determine the economic impact of policies on informal caregivers.

Regions of the Country

Region refers to a specific area of Canada having more or less definitely marked geographic boundaries and characteristics. To inform our selection of regions, we conducted a preliminary environmental scan of federal and provincial policies in three policy areas: health, income security and labour. Information from government Internet sites was compiled and reviewed. Three provinces were selected to maximize variability in policy regimes and their likely impact on informal caregivers.

Specific regions within provinces were selected because of the regionalization of health care and other services. Because setting may affect availability of, and access to, health care services, we selected three regions: large urban, small urban and rural. The three regions selected for comparison were the Capital Regional District of British Columbia, the Regional Municipality of Niagara in Ontario and the Cape Breton Island Region of Nova Scotia (Inverness, Richmond and Victoria counties). Statistics Canada has classified these regions as census divisions.

A statistical profile based on 1996 Census information is available on-line for most Canadian communities. Statistics Canada's (1998b) profile of Canadian communities was

the primary source for describing and comparing the three selected regions. The Statistical Profile of Canadian Communities Web site provides information on education, income and work, families and dwellings, as well as general population information for a given community or census division. In a few cases, the Statistics Canada information was supplemented with information from regional sources.

Capital Regional District of British Columbia

Located in western Canada on the southeast tip of Vancouver Island along the Juan de Fuca Strait, this region includes the communities of Victoria, Saanich, Oak Bay, Esquimalt and Colwood. The average population density was 480 people per square kilometre in 1996 and, for the purposes of this project, we classified this region as a large urban setting. The unemployment rate for the region was eight percent overall compared to the national average of 10 percent. The average total income of persons in the region who reported income in 1995 was $27,369 ($22,197 for women and $32,989 for men). Although the common perception is that the Capital Regional District attracts mainly retired people, the majority of migrants to the region are between the ages of 25 and 44 (Victoria 1999). Population growth is expected in all age groups, reflecting a pattern of in migration.

Regional Municipality of Niagara Ontario

Located in central Canada between Lake Ontario on the north, Lake Erie on the south and the Niagara River on the east, the region includes 12 communities: St. Catharines, Niagara Falls, Welland, Fort Erie, Grimsby, Lincoln, Niagara-on-the-Lake, Pelham, Port Colborne, Thorold, Wainfleet and West Lincoln. While the average population density in the region is 295 people per square kilometre, it ranges from 29 in Wainfleet Township to 1,386 people per square kilometre in the city of St. Catharines. For this project, we classified the region as a small urban setting. The average unemployment rate for the region was eight percent in 1996. The average total income of persons in the region who reported income in 1995 was $25,730 ($18,442 for women and $32,788 for men). The population of the Regional Municipality of Niagara tends to be relatively stable.

Cape Breton Island Region of Nova Scotia

Located in eastern Canada on the northeastern tip of Nova Scotia and surrounded by the Atlantic Ocean, the region includes the counties of Inverness, Richmond and Victoria, but excludes industrial Cape Breton, around the main city of Sydney. The population density of the region was 15 people per square kilometre in 1996 and for the purposes of this project, we classified the region as rural. The unemployment rate for the region was 29 percent overall, although there was considerable variation across the counties (minimum 21 percent in Inverness, maximum 49 percent in Victoria County). Unemployment rates in the region were at least double the national average of 10 percent in 1996. The average total income of persons in the region who reported income in 1995 was $18,807 ($13,562 for women and $23,788 for men), well below the 1996 national average of $25,196 ($19,208 for women and $31,117 for men). Many residents leave rural Cape Breton to attend post-secondary institutions or to find employment (Enterprise 1998), reflecting a pattern of out migration.

In summary, the three selected regions differ in population density, economy (as reflected by unemployment rate and average resident income) and migration patterns. These regional

differences may influence the availability and accessibility of formal services, the amount of disposable income available to pay for out-of-pocket expenditures related to elder care and the availability of informal caregivers.

Profiles of Informal Caregivers

There is considerable diversity among the nearly 11 percent (2.1 million) Canadians who provided informal care to seniors with a long-term health problem in 1996 (Keating et al. 1999). Female and male informal caregivers differ across demographic characteristics (e.g., age), competing demands (e.g., marital status, labour force status, presence of children) and caregiver–care recipient dyad characteristics (e.g., type and quality of the relationship between caregiver and care recipient). Such characteristics may influence the economic consequences of caregiving.

Given the heterogeneity of informal caregivers, profiles of prototypical caregivers were developed to compare the economic impact of policies on different types of caregivers, including differences between women and men. To develop profiles of informal caregivers, we used a three-stage process:

- analyzing data from the Statistics Canada 1996 General Social Survey (GSS);
- consulting with stakeholders; and
- analyzing data from the 1996 Census.

Three different types of informal caregivers, each with a male and female profile, emerged from this process. They included adult children with young children of their own, adult children without dependent children of their own and who are primary caregivers, and spouse caregivers. Each profile was used later in the project as a case study to determine the economic impact of health, income security and labour policies on each type of informal caregiver.

1996 General Social Survey

Initially, we analyzed the 1996 General Social Survey to create profiles of informal caregivers who were most involved in, or most affected by, their caregiving responsibilities. We used a subset of 1,366 respondents providing assistance to a senior with a long-term health or other disability. These people helped with one or more of the following tasks: meal preparation, housework, home maintenance and repairs, shopping, bills and banking, transportation and personal care.

To develop the profiles, we conducted chi-square automatic interaction detector (CHAID) analyses of the data. CHAID segments the samples according to characteristics that best distinguish groups of respondents on a given measure. We selected six key characteristics that have been shown to be important predictors of the experiences of informal caregivers (Keating et al. 1999): gender, employment status, having one or more children under the age of 15 years, being a primary caregiver, geographic proximity and relationship of the caregiver to the care receiver. We used these characteristics as explanatory variables in the CHAID analyses.

Dependent variables included time spent providing elder care and four measures of the consequences of caregiving experienced by informal caregivers: job adjustments, postponements, socio-economic consequences and burden (all defined in Appendix A). These measures were chosen because they are known costs to informal caregivers (Keating et al. 1999) and because of the potential to address the economic consequences they represent through public policy. Analyses were weighted so results were representative of the population. Scanning for commonalities across the results yielded four sets of characteristics or profiles.

- Profile 1 comprised women employed full time, with one or more children under age 15. These women experienced the greatest consequences overall in terms of job adjustments, postponed opportunities, feelings of burden and socio-economic repercussions. Twelve percent of female informal caregivers, or approximately 170,749 women in Canada, fit this profile.

- Profile 2 comprised men employed full time, who had one or more children under age 15. These men experienced the greatest consequences overall in terms of job adjustments, postponed opportunities, feelings of burden and socio-economic repercussions. These characteristics describe 29 percent of male informal caregivers, or about 269,318 men in Canada.

- Profile 3 comprised women who were primary caregivers, who did not have children under age 15 living at home. These women spent the most time caregiving and experienced high levels of burden and socio-economic consequences. These characteristics describe 33 percent of female informal caregivers, or about 463,895 women in Canada.

- Profile 4 comprised men who did not have children under age 15 and who were primary caregivers. These men spent the most time caregiving and experienced high levels of burden and socio-economic consequences. These characteristics describe 21 percent of male informal caregivers, or about 190,963 men in Canada.

Consultations with Stakeholders

After developing the statistical profiles, we consulted with stakeholders who had experience with a broad range of informal caregivers in order to personalize and validate the profiles. This consultation also allowed us to discuss how regional differences affect caregivers' lived experiences. Six individuals representing various regional, provincial and national organizations[1] participated in a two-day consultation group meeting in February 1999. Four of the six consultants represented caregiver associations or advocacy groups, one consultant was employed by a provincial government and another by the federal government. (See Appendix B for a list of names and affiliations.)

Consultants recommended that the profile of female and male caregivers who did not have children under 15 years and who were primary caregivers be refined to include separate profiles for spouses and older adult children. This brought the number of profiles to six (three types of informal caregivers, with a male and female version of each type). With additional input from consultants on caregiver characteristics, tasks performed and consequences experienced, each profile was further developed as described below. The

consultants reviewed these profiles to verify their face validity and to identify any details that were inaccurate or missing.

1996 Census

As a result of the policy scan, we determined that some programs were income tested. Thus, specific information was required on the income levels of caregivers and their care receivers to determine eligibility for some health and income security programs. Using the 1996 Census, we determined the average annual income from all sources by age group and gender for the selected regions. Caregivers' household income was obtained by adding together the average annual income of women and men in each age category by region. The average incomes for women and men over 75 were summed and used as the married care receiver's annual family income for each region. The average income of women over 75 years was used as the widowed care receiver's income for each region. The annual income level by gender and age for each region is presented in Appendix C.

The Six Profiles

Rebecca: Adult Daughter Caregiver with Young Children

Rebecca is in her early 40s. She is a married daughter (or daughter-in-law) of an elderly couple. She has two children under 15, and she is employed full time. Her mother is in her early 70s and her father is in his late 70s. Rebecca is not a primary caregiver for her father, but she assists her mother with caregiving tasks. She lives within commuting distance (half a day or less) of her parents who live in their own home. Rebecca and her husband are in the middle-income bracket but have little disposable income.

Rebecca telephones her parents frequently and visits whenever she can. She provides emotional and social support to them, especially to her mother, who worries about her husband. When she visits, she tries to do what she can by assisting with meal preparation, housekeeping, shopping and running errands. When her father needs extra assistance, Rebecca re-arranges her schedule so she can help more. She communicates with the formal health system, ensuring that her father's medical appointments are kept and follow-up is completed.

Rebecca feels guilty that she is not doing more to assist her parents. She experiences stress related to the competing demands of her children, paid employment and caregiving responsibilities. She finds she is not sleeping well. Her husband thinks she is trying to do too much and should focus on their own family. He thinks it is costing them too much financially and that she is using too many days off and vacation days to assist with caregiving, rather than for activities with their children and him. Rebecca keeps in touch with her siblings to discuss their father's care needs. They do not always agree about how to manage their father's needs.

Rob: Adult Son Caregiver with Young Children

Rob is in his early 40s. He is a married son[2] of an elderly couple. He has two children under 15 and is employed full time. His mother is in her early 70s and his father is in his late 70s. Rob is not a primary caregiver for his father, but he assists with caregiving tasks. He lives

within commuting distance (half a day or less) of his parents who live in their own home. Rob and his wife are in the middle-income bracket but have little disposable income.

Rob telephones his parents frequently. His parents enjoy the social support he provides when he visits or telephones. He has begun to take care of financial and legal matters for his parents.

While he generally does not let caregiving interfere with his employment, his wife is starting to complain about the time and money that his caregiving involves. She was unhappy that he had used up most of his days off and vacation time to assist with caregiving rather than spending time with their children and her. Rob keeps in touch with his siblings to discuss their father's care needs. They do not always agree about how to manage their father's needs. He is starting to experience stress related to the time caregiving requires and his siblings' unwillingness to do more.

Joan: Adult Daughter without Dependent Children Who Is a Primary Caregiver
Joan is in her 50s. She is the married daughter (or daughter-in-law) of an elderly widow. Her children are over 18, but one child still lives at home. She is employed full time. Her mother experiences chronic physical impairment and some minor cognitive impairment. Joan has been the primary caregiver for her mother, who is in her 80s, for the last five years. She lives in the same neighbourhood as her mother. Joan and her husband are in the middle income bracket.

Joan takes care of the majority of her mother's household tasks including cooking, laundry and cleaning. She takes her mother grocery shopping on a weekly basis and assists her with meal preparation. Joan and her family transport her mother to appointments. Joan calls her mother every evening and visits with her mother three to four times a week. Joan co-ordinates her mother's medical care, including her medication. Joan's mother needs some assistance with dressing and bathing. She receives few supportive services from the formal sector and, when she asks for help, often finds that her needs are questioned. A formal caregiver does some personal care for her mother once a week, while Joan assists her mother with personal care at other times. Joan also has taken over managing her mother's financial and legal matters.

Joan finds that her caregiving responsibilities require her to adjust her work hours, to miss work and to use up her vacation days. She is avoiding taking on any additional responsibilities at work and is considering whether she should give up her paid employment because of the demands of caregiving. Joan finds that she has virtually no time to meet her own needs or those of her immediate family. She notices increasing signs of stress. She feels her own health is deteriorating and she is not sleeping well. Joan has begun to ask her siblings to help more and tension is increasing among the siblings around sharing caregiving responsibilities.

John: Adult Son without Dependent Children Who Is a Primary Caregiver
John is in his 50s. He is the married son of an elderly widow. His children are over 18 but one child still lives at home. He is employed full time. His mother experiences chronic physical impairment and some minor cognitive impairment. John has been the primary

caregiver for his mother, who is in her 80s, for the last five years. He lives in the same neighbourhood as his mother. John and his wife are in the middle income bracket.

John and his wife take care of the majority of his mother's household tasks including cooking, laundry and cleaning. They also take care of his mother's shopping and transportation needs. He calls his mother every evening and visits with his mother three to four times a week. He co-ordinates his mother's medical care, including her medication. He is not hesitant about asking for supportive services from the formal sector, and he usually gets services when needed. John's mother needs some assistance with dressing and bathing. A formal caregiver does some personal care for his mother during the week, while his wife assists his mother with personal care at other times. He takes care of financial and legal matters for his mother.

John's employment is not unduly affected by his caregiving responsibilities because his job affords him a flexible work schedule. He generally maintains his own interests but he is experiencing some stress. John wishes that his sister, who lives about 200 km away, would help more.

Edith: Spousal Caregiver

Edith is in her early 70s. She is the primary caregiver for her husband who is in his mid to late 70s. He has both physical and cognitive impairments. Edith is affected by chronic health problems as well. They live in their own home that is their primary asset. Their income is derived primarily from Old Age Security (OAS), her husband's Canada Pension Plan (CPP) benefits, and a small amount of savings. One of their three children lives nearby, one within a half day's drive and the third in another city. Her husband is no longer able to drive and she does not drive.

Edith believes in doing as much as she can herself. She assists with her husband's personal care and she manages his health care, including medications. She does all the routine household tasks such as cooking, cleaning and laundry. Some of the more physically demanding household tasks, such as washing floors and windows, are not completed as frequently as needed. Family members or neighbors do the heavy outdoor work, such as mowing the lawn and shovelling snow. Most of the home maintenance and repair work, such as painting or fixing a leaky roof, is left unattended. Edith asks for assistance with transportation for shopping and medical appointments from her family members and neighbours, but also uses taxis at times. Her husband is no longer able to attend to financial matters so her adult children assist her and the local bank staff are also helpful.

Edith feels increasingly isolated. She finds taking care of her husband demanding and lonely. Her own health and coping skills are deteriorating as she experiences greater stress and less autonomy. She is concerned about getting a good night's sleep. Her husband wakes her up at night. Edith worries about who will care for her husband if her own health deteriorates further. Finances are beginning to worry her as costs associated with her husband's care increase. She also wonders how they will afford facility care if he needs it.

Ervin: Spousal Caregiver

Ervin is in his mid to late 70s while his wife is five years his junior. He is the primary caregiver for his wife who has both physical and cognitive impairments. He is affected by chronic health conditions as well and experiences a moderate degree of hearing loss. They live in their own home that is their primary asset. Their income is derived primarily from Old Age Security, his Canada Pension Plan benefits and a small amount of savings. One of their three children lives nearby, one within a half day's drive and the third in another city. Ervin still has a driver's licence, although he is concerned about what will happen if he loses it, and he hates the thought of having to ask others to take him places.

While Ervin isn't used to some of the tasks he has taken on, he believes he and his wife should try to take care of themselves. He assists with his wife's personal care and co-ordinates her health care, including medications. He does most of the routine household tasks, such as cooking, cleaning and laundry. Many of the more demanding household tasks, such as washing floors and windows, are not done unless his daughter or daughter-in-law does them. Because he is still able to drive, he takes care of shopping and other errands. However, this usually requires asking a neighbour or family member to stay with or check on his wife. His children or neighbours do the heavy outdoor tasks, such as mowing the lawn and shovelling snow, although he would like to help. Most home maintenance and repairs, such as painting and fixing a leaky roof, are left unattended. He manages their financial and legal matters with help from the staff at the local bank.

Ervin is finding the increasing isolation and decreasing independence due to his wife's needs more and more frustrating. His health and coping skills are deteriorating as the demands increase and as he is affected by disrupted sleep. Financial concerns are an increasing worry for him as he wonders how they will cover the growing costs of his wife's care. He wonders how they will afford facility care if she needs it. Ervin is also starting to worry about who will care for him if his own health deteriorates further.

Summary of Profiles

These profiles represent three types of informal caregivers (with a female and male profile of each) who are most involved in, or most affected by, their caregiving responsibilities: adult children with young children of their own (Rebecca and Rob), adult children without dependent children of their own who are primary caregivers (Joan and John) and spousal caregivers (Edith and Ervin). These caregiver profiles were used later as case studies to analyze the economic impact of health, income security and labour policies on different types of caregivers living in different regions of the country. We anticipated a differential economic impact of policies among caregiver profiles, given the variability of characteristics and income.

Scan of Current Health, Income Security and Labour Policies

There are three policy areas in which ongoing reform may have a significant impact on seniors' informal caregivers: health, income security and labour policies. Reductions in federal transfer payments, and in provincial health and home care funding likely contribute to pressure on informal caregivers to increase their unpaid work. Pension reform may reduce seniors' current income and, hence, their ability to meet out-of-pocket expenses related to

elder care. Pension reform also may reduce the future income of informal caregivers, and welfare policy changes may affect the current income of care providers who forfeit paid employment to provide elder care. While employers may have family-friendly workplace policies, we know little about how government policies enable informal caregivers to balance their work and family responsibilities without jeopardizing their jobs and current income. While other policy domains, such as housing and transportation, may affect informal caregivers economically, the programs reviewed were limited to the domains of health, income security and labour. However, the framework developed in Chapter 3 is intended to be applicable to any policy domain.

A key step in policy analysis is gathering "information about the social problem and the sociopolitical environment" (Majchrzak 1984: 21). The policy scan is a snapshot of health, income security and labour programs in place as of June 30, 2000, which may directly or indirectly affect the economic status of informal caregivers. While the provision of programs for caregivers, such as support groups, health education and training, is important, and the lack of such programs may affect caregivers' physical, social and emotional well-being (i.e., have non-economic consequences), these programs were excluded from the policy scan because they are largely governed by the voluntary and private sectors. Information on policy instruments was gathered from federal and three selected provincial and regional governments. Regional information was necessary because regions differ in their economic, social and demographic resources. In addition, responsibility has been devolved from provincial to regional governments, primarily within the health domain. Therefore, regional differences may affect the availability of services and, thus, the economic well-being of informal caregivers.

Information on policy instruments was gathered from federal, provincial and regional government Internet sites and program documentation. Benefits were clarified with program representatives as needed. Federal government Web sites that were examined were those of the Canada Customs and Revenue Agency, the Department of Justice, Human Resources Development Canada (HRDC), and Health Canada and its Division of Aging and Seniors.

In British Columbia, public policy instruments were gathered from the Web sites of the ministries of Health, Labour, Social Development and Economic Security, and the Office for Seniors. Information on programs in the Capital Regional District was collected from regional directories of community services for seniors.

In Ontario, public policy instruments were collected from the Web sites of the ministries of Community and Social Services, Finance, Health and Long-Term Care, and Labour. The Web site of the Department of Community Services for the Regional District of Niagara provided information on regional programs for seniors.

In Nova Scotia, public policy instruments were compiled from the Web sites of the departments of Community Services, Health, and Labour, and the policy and procedure manual for Home Care Nova Scotia. A directory of programs for seniors published by the Nova Scotia Senior Citizens Secretariat, staff of the Eastern Division of Home Care Nova Scotia, and the Cape Breton Regional Municipality Web site provided information on programs in rural Cape Breton. Programs were clarified with representatives as needed.

In searching for relevant policy instruments within the domains of health, income security and labour, we looked at programs that may have direct or indirect economic impacts on informal caregivers. By direct, we mean policy instruments that specifically target informal caregivers. However, we found that many policy instruments target others, such as care receivers, seniors in general and employees, but could have indirect or unintended economic consequences for informal caregivers. Thus, public policy instruments reviewed in this scan include those that target informal caregivers, care receivers, seniors, individuals with disabilities, employees and all Canadians, which may have direct or indirect economic consequences for informal caregivers. A complete list of documents reviewed is given in Appendix D. Programs are described in terms of their intent, benefits provided, eligibility criteria used and client fees levied (where applicable). This knowledge assists us in determining the availability of programs for seniors and their caregivers and, hence, the likely economic impact of policies on informal caregivers.

Health Programs

The majority of health programs examined are designed specifically to serve the needs of seniors, particularly frail seniors living in the community. However, they may affect informal caregivers' unpaid labour and out-of-pocket expenditures for such things as drugs, equipment, and other health care supplies and services. Health programs reviewed include home care programs, adult day programs, consultation services of allied health professionals, drug plans, home oxygen programs, equipment programs, and physician and hospital services.

Home care

Extended health care services, such as home care, are not included within the mandate of the *Canada Health Act*. Responsibility for the provision of home care services rests with the provinces and, in recent years, many provinces have devolved responsibility for health, including home care, to regional governments (Health Canada 1999). All three regions surveyed offer home care programs that encompass case management, personal care, homemaking and nursing services. Respite often is not a separate program. Rather, additional personal care and homemaking services are provided to give respite to those caregivers who are in need. Case managers are responsible for the assessment, determination of eligibility and co-ordination of home care services for clients. Fees are charged to clients for homemaking and other support services. Program intent, eligibility criteria and fees for home care services to seniors differ among the three selected regions.

British Columbia: In British Columbia, community-based continuing care services are designed to supplement rather than replace the efforts of individuals to care for themselves with the assistance of family and friends (B.C., Office for Seniors 1999). Long-term care case managers provide assessment, consultation, referral, ongoing monitoring and review, and co-ordination of a variety of services that assist seniors to live at home independently and safely (Seniors Serving Seniors 1998/99). These services include homemaking, personal care, caregiver respite (in home or through short-term facility admission), nursing services and adult day programs.[3] Residential care facility placement is also arranged for those unable to stay at home. Home care eligibility criteria include:

- Canadian citizenship or landed immigrant status;
- permanent residency in British Columbia for one year prior to assessment;
- 19 years of age or older; and
- presence of a chronic or progressive medical condition that is expected to last three months or longer (Seniors Serving Seniors 1998/99).

Effective April 3, 2000, all clients in the Capital Regional District, who are referred for long-term care services, are screened with a Priority Screening Tool (Maatbuis and Miller 2000). The tool was designed to determine the level of risk a client is under regarding illness/injury to self or others, or caregiver breakdown. Case managers see all clients assessed at medium or high probability of risk levels. Only these clients are eligible for subsidized home support services (cleaning is now an excluded service), case management, adult day programs and short-term facility admissions. Clients assessed at the low priority level are given information about other resources available in the community.

There is no direct cost to clients for case management services. However, client fees for assistance with personal care and homemaking vary according to net income (line 236 of the federal income tax return) and family size. Fees range from $1 to $10 per day regardless of the number of visits per day. There is no charge for personal care and homemaking services for seniors who receive Old Age Security and either the federal Guaranteed Income Supplement (GIS) or the War Veterans Allowance. The provincial Medical Services Plan (MSP) covers home nursing care costs, but clients are responsible for the cost and provision of medications and supplies (Seniors Serving Seniors 1998/99). Bathing programs are available in the Capital Regional District following surgery, a fall, a fracture, application of a cast, an illness or for those experiencing difficulty getting in or out of the bathtub at home, even with the use of grab bars or bath seats. Bathing programs are based out of several community care centres and costs range from $5 to $10 per bath.

Ontario: The Ministry of Health and Long-Term Care mandates that all community care access centres (CCACs) provide a set of core services: information and referral to all continuing care services (including volunteer-based community support services), co-ordinated service planning and monitoring, assessment and eligibility determination for services provided by nurses, physical therapists, occupational therapists, speech-language pathologists, social workers and dietitians; homemaking services, personal care services, case management and placement co-ordination services for admission to residential care facilities. Case managers employed by CCACs are responsible for assessing eligibility, determining service needs, developing service plans, authorizing provision of service, co-ordinating the delivery of multiple services, monitoring ongoing service needs and planning for discharge when services are no longer required. The need for personal care services is no longer a prerequisite to qualify for assistance with homemaking services. However, in Niagara, clients who do not require personal care assistance receive CCAC-funded homemaking services only in extenuating circumstances and with management approval. CCAC core services are available to people of any age who meet the following eligibility criteria.

- The individual is an Ontario resident insured under the Ontario Health Insurance Plan (OHIP).

- The individual's condition hinders her/his ability to have needs met through outpatient departments and clinics in the community.

- The condition is such that adequate treatment can be provided at home with the services available through the CCAC.

- The client's home is suitable for the provision of the required care.

- The client's family or other appropriate persons are willing and able to participate in the program as required (Ontario, Ministry of Health 1999).

Two levels of respite are available to support caregivers, although the associated out-of-pocket costs differ. The primary Respite Care Service, co-ordinated by CCACs, provides short- and long-term respite services within maximum resource allocations to the caregivers of clients eligible for home care services. The Ministry of Health and Long-Term Care funds community support service providers for the administration and co-ordination costs of providing the primary Respite Care Service only. In comparison, the Extended Respite Service can be purchased by clients who want more service than the CCAC has assessed them eligible for; who are on the waiting list for CCAC service but not a priority for service; or who want to supplement services provided by the CCAC for persons who require extensive amounts of respite service on either a short- or long-term basis. The direct labour and transportation costs of providing the Extended Respite Service must be recovered from client fees, donations, fund-raising or the use of volunteers (Ontario, Ministry of Health 1999). In the Niagara Region, attendant care is not a CCAC contract service, although they do manage short-stay respite. The Seniors Services Division of the regional municipality's Community Services Department offers the Respite Companion Program in which in-home respite care is provided for a person providing 24-hour care to a family member who has Alzheimer disease or memory loss. Approximately 12 beds are available in the Niagara Region for short-stay respite. The maximum length of stay per client is 30 consecutive days, not to exceed 90 days per year. The short-stay accommodation fee charged is $29.29 per day per client.

Clients are not charged fees for personal care, nursing or allied health professional services that are set out in their plan of service by the CCAC. Current legislation and regulations permit fees to be charged for homemaking and other community support services, such as meals on wheels, wheels to meals/diners club, transportation, adult day programs, home maintenance and repair. From time to time, the Ministry may add other services to this list, such as the Alzheimer respite/companion program. Clients can purchase services in excess of Ministry guidelines from agencies contracted by the CCAC or other home support agencies.

Nova Scotia: Services provided under Home Care Nova Scotia's Chronic Home Care Program are meant to maintain or improve the level of functioning, address unmet needs during rehabilitation or convalescence, delay or prevent admission to institutions, and

provide relief to clients' informal caregivers. The Chronic Home Care Program provides home support services, personal care services, nursing services and home oxygen services to persons with assessed unmet needs who are convalescing, chronically ill, disabled or experiencing debilities of old age. Care co-ordinators assess individual clients, establish and implement a resource allocation plan, act on the client's behalf to arrange for needed services, make referrals to volunteer services as required and consult with others on a regular basis. Home support services include meal preparation, light housekeeping and laundry, but exclude assistance with shopping, banking and other errands. In rural Cape Breton, home support workers employed by one of nine agencies contracted by Home Care Nova Scotia provide personal care and home support services. The Department of Health provides nursing services, whereas in most other areas in Nova Scotia, the Department contracts nursing services to organizations such as the Victorian Order of Nurses. Any services provided by Home Care Nova Scotia, which are normally provided by primary informal caregivers, may be provided on a family relief basis, if staff is available in the area. These respite services are provided at a client's home for short periods of time. Services are available to people who meet the following eligibility criteria.

- The individual is a resident of Nova Scotia and has (or is in the process of applying for) a Nova Scotia Health Care number.

- The individual has an unmet functional need such that he/she will be at risk of increase to, or continuation of, illness, injury, institutionalization or informal support network collapse if the home care services are not provided.

- The individual's physical condition limits her/his ability to reasonably access the necessary care from community-based services, such as outpatient departments, clinics or physicians' offices.

- The individual requires home support, nursing and personal care services, and Home Care Nova Scotia is the most suitable method of providing the amount, level and type of service required.

- The individual's condition and situation is such that he/she could be cared for safely and effectively at home with the services available through Home Care Nova Scotia.

- The individual's residential environment is safe and suitable for the provision of home care services, both for the individual and for the formal caregiver.

- The individual is willing to accept the home care service according to the developed resource allocation plan.

- Services required by the individual generally do not exceed the cost of the equivalent level of services in a licensed health care facility (Home Care Nova Scotia 1997).

In addition to meeting these general eligibility criteria, participants in the Chronic Home Care Program have to meet the following four conditions.

- They require ongoing care in the home, as a result of chronic illness, disability, debilities of old age or convalescence, or require short- or long-term oxygen therapy for chronic hypoxemia.

- They must be functionally unable to carry out their own independent and instrumental activities of daily living.

- They have an intermittent need for care.

- They have a family physician if they are in receipt of nursing services (Home Care Nova Scotia 1997).

Individuals eligible for Home Care Nova Scotia are generally entitled to a maximum combined value of services and medical supplies of $2,200 per month, based on assessed unmet need. Maximum allowable services are calculated using provincially averaged unit costs for home support and nursing services. No fees are charged for nursing services, for physician services provided through Medical Services Insurance (MSI) or for personal care services provided by a licensed practical nurse or a registered nurse if an individual's condition warrants a professional. There is no charge for medical supplies on the Approved Supplies List that are used during nursing visits to support the care plan of an individual in the Chronic Home Care Program. The client or family member has to obtain, pay for and transport all medications, have in place any medications to be administered during nursing visits and provide needed supplies between nursing visits. Clients are charged hourly fees for personal care, home support and respite services provided by home support workers, up to a monthly maximum of $360 per month. Client charges are based on net family income, as defined by the *Income Tax Act*, and the size of the care receiver's family (spouse and dependants). There are no fees for services provided to individuals whose net income falls below the designated threshold based on family income and size, or who are in receipt of income-tested government benefits (e.g., Guaranteed Income Supplement, income assistance, family benefits).

Adult day programs

Adult day programs are support services for people living at home that provide needed health services and opportunities for socialization in a group setting to prevent premature and inappropriate institutionalization, and to provide respite for informal caregivers (Hollander and Walker 1998; Ontario 1999). Adult day programs are not available in all three regions but, where available, programs charge daily fees.

British Columbia: Access to adult day programs is co-ordinated through long-term care case managers. The Capital Health Region's adult day programs provide socialization, professional monitoring and nutritious meals to seniors who need assistance due to health-related disabilities. There is a daily charge of $6 that includes a meal and transportation.

Ontario: Access to adult day programs is co-ordinated through case managers at CCACs. In the Niagara Region, the Seniors Services Division of the regional municipality's Community Services Department, operates Adult Day Services. While the eligibility age is 18 and over, the program targets people 60 years of age or over who are living alone or

with family in the community, and who are not in residential continuing care. Many who attend the adult day programs are on a wait list for long-term care placement. The focus is on those seniors who are cognitively impaired, physically frail or socially isolated. Day programs are located in six long-term care facilities and at free-standing centres in Grimsby, Thorold and Niagara Falls. Daily fees of $12 to $29 are charged depending on income. One adult day program in the region operates an overnight and weekend component, providing accommodation, supervision, meals and activities to relieve informal caregivers. Access to the overnight program is available to individuals who attend the adult day program. Because only one bed is designated for the overnight program, stays are limited to one night. Fees equivalent to the short-stay accommodation fee for a residential continuing care facility are charged.

Nova Scotia: In contrast to the previous two regions, adult day programs are not available in rural Cape Breton. There is one adult day program in Sydney while another is located in the nearby town of Sydney Mines.

Consultation services of allied health professionals
Consultants include physical therapists, occupational therapists, social workers, dietitians and speech-language pathologists. Consultant availability varies among the surveyed regions.

British Columbia: Physical and occupational therapists from the Community Rehabilitation Program provide assessment, treatment, consultations and education in clients' homes to promote and maintain optimal functional independence in a safe environment. Services focus on non-urgent rehabilitation and client independence, pain management, palliative care, and pre- and post-surgical care. Recommendations are offered for environmental adaptation, aids for daily living and other mobility equipment, retraining and modifications to restore functional activity and independence, home safety, perceptual and cognitive testing, cardio-respiratory care, energy conservation and stress management. Services are available through the Community Rehabilitation Program to those individuals who are 19 years of age or older, homebound, a Canadian citizen or landed immigrant, a permanent resident of British Columbia, and a permanent or temporary resident of the Capital Health Region. There is no direct cost for rehabilitation services to clients, but clients are responsible for the cost and provision of supplies and equipment (Seniors Serving Seniors 1998/99).

Ontario: Access to physical therapy, occupational therapy, social work, dietetic and speech-language pathology services are arranged through CCACs. Services are available to individuals who meet the CCAC eligibility criteria. There are no charges to clients for the services of these allied health professionals.

Nova Scotia: The services of allied health professionals, including rehabilitation therapists, nutrition counsellors and social workers, are not available directly through Home Care Nova Scotia, although these services may be available in the community through other agencies. Physical therapy services in rural Cape Breton around Baddeck (Victoria County) are accessed through the Arthritis Society of Nova Scotia on a fee-for-service basis. Speech-language pathology services in the Sydney area are accessed through the Nova Scotia Hearing and Speech Clinic, an independent, non-profit agency.

Drug plans
Drug plans are provincial insurance programs that subsidize the cost of prescription medications. We focussed on those drug programs intended for seniors. While all the target regions had drug plans, the extent of coverage and costs varied considerably.

British Columbia: The B.C. Pharmacare program provides coverage to permanent residents of British Columbia who are 65 years of age or older, and who possess a Gold CareCard issued by the Medical Services Plan of British Columbia. Under the plan, seniors pay the first $200 of dispensing fees for each calendar year while Pharmacare provides 100 percent coverage of drug costs. Pharmacare reimburses seniors for dispensing fees paid in excess of $200. Pharmacare does not cover non-prescription drugs or vitamins.

Ontario: The Ontario Drug Benefit Program provides coverage for prescription drugs, nutritional products and diabetic testing products. Individuals are eligible for coverage if they meet one of the following criteria: 65 years of age or over, resident of a continuing care facility, resident of a home for special care, receiving professional services (such as nursing or rehabilitative services) under the Home Care program, or a Trillium Drug Program recipient (for those with high prescription drug costs in relation to income). Level of benefit is based on income. A single senior with an annual net income of more than $16,018 or a senior couple with a combined annual net income of more than $24,175 are each required to pay the first $100 in prescription drug costs and then up to $6.11 for each prescription thereafter. Alternatively, clients pay up to $2 per prescription if they are low income, receive home care professional services, are a resident of a nursing home, home for the aged or home for special care, receive general welfare benefits or family benefits, or are a Trillium Drug Program beneficiary.

Nova Scotia: The provincial Pharmacare provides coverage for eligible seniors 65 years of age and over. People covered by Veterans Affairs Canada, Indian and Inuit Health Services, or those with private insurance, are not covered by the Nova Scotia Seniors' Pharmacare Program. For the fiscal year beginning April 2000, the Pharmacare premium is $215 annually plus a 20 percent co-payment for each prescription cost to a maximum of $350 per year. Seniors are eligible to apply for a reduced premium if their annual income falls below $18,000 for single seniors or $24,000 for senior couples. Seniors who receive the Guaranteed Income Supplement from the federal government are not required to pay the annual premium. Pharmacare covers approximately 3,500 medications approved for coverage by the Nova Scotia Department of Health and dispensed in Nova Scotia. The list of drugs insured by Pharmacare changes as new drugs are marketed and new information becomes available.

Home oxygen programs
Home oxygen programs are intended to provide necessary equipment and supplies to individuals who have insufficient oxygenation of their blood (chronic hypoxemia). All three provinces have a home oxygen program although the extent of coverage and costs vary. Often, the costs of necessary equipment and supplies are competitive or subsidized.

British Columbia: The Home Oxygen Subsidy Program provides 100 percent reimbursement for oxygen and related equipment delivered to the homes of individuals who

meet established criteria. Individuals are approved for rental of an oxygen concentrator if they satisfy medical eligibility criteria (i.e., blood oxygen levels below a certain standard). Payment is made for the most economical system consistent with individual need and lifestyle. Suppliers are determined regionally through a scheduled bidding process.

Ontario: Similarly, the provincial Home Oxygen Program pays for oxygen, oxygen delivery equipment and related supplies. The Home Oxygen Program pays 100 percent of the costs of oxygen and related equipment for seniors, individuals on social assistance, or clients who receive home care or who reside in a continuing care facility. For those individuals who do not meet these criteria, the Home Oxygen Program pays 75 percent of the costs. Clients then pay a share of the cost at the time of purchase and the vendor bills the Home Oxygen Program for the balance.

Nova Scotia: Home Care Nova Scotia is the insurer of last resort for home oxygen services. Clients must first access home oxygen services from private medical insurance coverage or other publicly funded programs, such as Veterans Affairs Canada. Home oxygen services are provided to home care clients who experience chronic hypoxemia, who require an oxygen concentrator, and who meet medical eligibility criteria and Home Care Nova Scotia general eligibility criteria. If all eligibility criteria are met, clients receive home oxygen services through a roster of approved vendors. The Home Oxygen Program covers the costs of oxygen concentrators, emergency oxygen backup tanks, associated supplies, education and maintenance of equipment. Costs associated with home oxygen services are not included in calculations for monthly maximum allowable services under the Home Care Program. Clients receiving home oxygen services are assessed a monthly service fee ranging from $60 to $240 depending on net family income and the size of the client's family (spouse and dependants). Home Care Nova Scotia clients who receive both home oxygen services and home care services are charged only the home oxygen fee and, as a result, the home care fee of up to $360 per month is waived.

Equipment plans

These provincial programs subsidize the costs of equipment required by individuals with physical disabilities. The cost of essential equipment is often significant, but only one province has a publicly funded equipment subsidy program.

British Columbia: There are no publicly funded medical equipment subsidy plans, although there are several charitable equipment loan programs in the Capital Regional District.

Ontario: The Assistive Device Program, funded by the Ontario Ministry of Health and Long-Term Care, financially assists people with long-term physical disabilities to obtain basic, competitively priced, personalized assistive devices appropriate for their needs and essential for independent living. Devices covered by the program are intended to give people increased independence and control over their life, enhance their ability to remain in a community living arrangement and, thereby, avoid institutional settings that are more costly to the province. The Assistive Device Program covers 15,000 separate pieces of equipment or supplies within the following categories: prostheses, wheelchairs, mobility aids and specialized seating systems, ostomy and enteral feeding supplies, needles and syringes for insulin-dependent seniors, monitors and test strips for insulin-dependent diabetics, hearing

aids, respiratory equipment, orthoses, and visual and communication aids. Specific eligibility criteria apply to each device category. For most equipment, the Assistive Device Program pays up to 75 percent of the cost of the equipment. For specific types of equipment, such as hearing aids, the Assistive Device Program contributes a fixed amount per period ($500 per hearing aid every three years). In most cases, clients pay a share of the cost at purchase, and the vendor bills the Assistive Device Program for the balance. For items, such as ostomy supplies, and needles and syringes for diabetic seniors, the Assistive Device Program pays an annual grant directly to the person. Clients then pay 100 percent of the cost to the vendor.

Nova Scotia: Home Care Nova Scotia clients are responsible for borrowing, renting or purchasing medical equipment required in the home, except equipment provided through home oxygen services. Individuals in receipt of income-tested government benefits may be eligible for financial assistance with equipment under these existing programs (i.e., guaranteed income supplement, family benefits, income assistance or in-home support).

Physician and hospital services

All three provinces have medical insurance plans that cover most physician and hospital services required by residents. Eligibility criteria are similar across provinces, although the services covered and costs vary. Only two provincial programs cover supplementary health care, and the range of these services varies.

British Columbia: The Medical Services Plan (MSP) pays for medical and health care services on behalf of residents of the province. This includes all medically required services of general practitioners and specialists, laboratory services and diagnostic procedures (including X-rays and ultrasound examinations), and dental and oral surgery when performed in a hospital. Supplementary health care benefits are also provided through MSP, including chiropractic, dental surgery, massage therapy, naturopathy, physical therapy, optometry and podiatric services. However, there are limits on how much service the MSP pays per client per year.

To qualify for medical coverage under MSP, an individual must be a Canadian citizen or be lawfully admitted to Canada for permanent residence, must make her/his home in British Columbia, and must be physically present in British Columbia at least six months in a calendar year. Monthly premiums based on family size and income are charged to those enrolled with the Medical Services Plan. Subsidies range from 20 to 100 percent for those in financial need. Assistance with premiums is based on an individual's net income for the previous year or a couple's combined net income, less deductions for age ($3,000 if over 65 years), family size and disability. If the resulting amount, referred to as adjusted net income, is $20,000 or less, a subsidy is available.

Ontario: OHIP covers all essential diagnostic and treatment services by physicians and hospital staff, dental services in hospitals and examinations by optometrists. It also covers portions of the cost of services provided by podiatrists, chiropractors, osteopaths and physical therapists, although there are limits on how much service OHIP covers per client per year. Individuals who are Canadian citizens, permanent and principal residents of

Ontario, and who live in Ontario for at least 153 days in any 12-month period are eligible for provincial health insurance. There are no premiums for OHIP.

Nova Scotia: Medical Services Insurance (MSI) covers essential diagnostic and treatment services by physicians and hospital staff. Individuals who are Canadian citizens or landed immigrants, permanent and principal residents of Nova Scotia, and who live in Nova Scotia for at least 183 days in any 12-month period are eligible for provincial health insurance. There are no premiums for MSI.

Summary of health policies

Table 1 provides an overview of the availability of health programs in the three regions. As shown, all three regions provide a core set of health care services. Other health programs may be available only in one or two jurisdictions. The federal government does not provide direct health services, but rather provides funding for health care through the Canada Health and Social Transfer.

Table 1. Summary of Availability of Health Programs across Jurisdictions

Health Program	Federal Government	Capital Region (BC)	Niagara Region (ON)	Cape Breton Region (NS)
Home care		✔	✔	✔
Adult day programs		✔	✔	
Consultation services		✔	✔	
Drug plan		✔	✔	✔
Equipment plan			✔	
Home oxygen program		✔	✔	✔
Physician and hospital services		✔	✔	✔

Eligibility for health care programs was based largely on care receiver characteristics, although eligibility for home care programs also depended on availability of informal caregivers to assist. The user fees charged by various health care programs may increase the out-of-pocket expenses of seniors who qualify, or of their informal caregivers in situations where they are subsidizing these costs for the senior for whom they are caring. Health care programs may have little effect on the unpaid labour provided by informal caregivers because formal and informal care are not substitutes (Penning and Keating 2000).

Regional differences may exist in out-of-pocket expenses incurred by informal caregivers for health care services because of differences among the regions in the availability of health care programs, the eligibility criteria used, level of benefits provided and user fees charged. For example, Ontario is the only province to offer a subsidized equipment program. The lack of availability of this type of program in other jurisdictions will have economic consequences for informal caregivers, in terms of additional out-of-pocket expenses for medically necessary equipment in situations where the senior is unable to meet the cost.

Income Security Programs

Income security programs reviewed include social assistance programs, pension plans, guaranteed annual income programs, and income tax deductions and credits. While the majority of the income security programs examined were intended for individuals with low incomes, seniors and individuals with disabilities, the programs may have unintended impacts on the economic status of informal caregivers (e.g., current and future income, and out-of-pocket expenses).

Social assistance programs

Provincial governments are responsible for providing income support programs that ensure minimum levels of income to people in need. British Columbia and Ontario have moved from "welfare" to "work" models of social assistance; Nova Scotia is in the process of moving to a similar system with standardized rates that will come into effect on April 1, 2001. The intent is to encourage people to become more self-reliant by requiring them to seek employment or training.

British Columbia: The Ministry of Social Development and Economic Security considers itself the "payer of last resort" (B.C. Ministry of Social Development 1999). Given this stance, support and shelter income are available to people who are unemployed or who earn very little, are awaiting other income or unable to work. The *BC Benefits Act* provides the legislative framework for financially assisting eligible individuals who are age 25 and over, and children living away from home or living in the home of a relative. Eligibility depends on income, assets and family composition, which takes into account the number and ages of both adults and children in the home. The rate of monthly assistance paid varies accordingly. Most recipients are required to look for a job or take training as a condition of receiving assistance, although participation in job training is optional for adults over 60 years. Exceptions may also be made for persons with physical or mental disabilities, single parents with at least one child under 7 years of age, and persons recently separated from an abusive spouse. Although caring for dependent adults does not exempt recipients from the requirement to seek work or participate in training, employable individuals who are caring for an ailing dependant may be excused temporarily from training or searching for a job.

Ontario: Ontario Works is a mandatory program for most social assistance recipients. Ontario Works has three components: employment supports, employment placement and community participation. To receive income support, individuals must make use of a variety of employment supports, participate in community placements, actively look for work and accept any offers of employment. Participation in Ontario Works is optional for lone parents with young children, seniors and persons with disabilities. Other exemptions are granted on an individual basis. Valid reasons may include becoming temporarily sick or injured, or taking care of a child, an adult with a disability or an aged family member who needs regular care.

Nova Scotia: The social assistance system has been undergoing changes since 1997. The Social Assistance Redesign Initiative creates a single administrative program that provides income support, active employment benefits and support for labour market participation. Financial assistance is provided on the budget deficit system in which assistance is given in

the amount by which financial needs for basic requirements, such as food, clothing and shelter, exceed income, assets and other resources. In April 2000, new standardized interim rates of assistance were established for people coming into the social assistance program. For people already on social assistance, the new standardized rate system will come into effect on April 1, 2001. It is not clear whether an informal caregiver in Nova Scotia who is unable to work because of elder-care responsibilities is eligible now, or will be under the new rules, for social assistance.

Pension plans

The federal government, through Human Resources Development Canada administers two federal government programs that provide financial benefits directly to individuals: the OAS program and the CPP. The legislation, which underpins these income security programs, is the *Old Age Security Act* (R.S., c. 0-6, s.1) and the *Canada Pension Plan* (R.S., c. C-5, s. 1).

As the cornerstone of Canada's retirement income system, the OAS program is financed from federal government general tax revenues. The OAS pension is a monthly benefit available to individuals age 65 years and over who have been residents of Canada for a minimum of 10 years after age 18. The level of benefit is determined by length of residence in Canada. Individuals who qualify for the full pension receive $424.12 per month. OAS benefits are "clawed back" for seniors whose annual incomes are more than $53,215 (HRDC 2000). The repayment is 15 percent of the amount that exceeds $53,215 up to the annual OAS benefit. All benefits payable under the *Old Age Security Act* are indexed quarterly based on increases in the cost of living as measured by the Consumer Price Index. OAS pensions are subject to federal and provincial income taxes.

In contrast to OAS, the CPP is a contributory, earnings-related social insurance program financed through contributions from employees, employers and self-employed persons as well as interest from the Canada Pension Plan Fund. The CPP ensures a measure of protection to a contributor and the contributor's family against the loss of income due to retirement, disability or death. The CPP covers nearly all employed and self-employed persons in Canada (except Quebec, which has its own similar pension plan) who are between the ages of 18 and 70, and who earn more than a minimum amount. Any person who has made at least one valid contribution to the CPP is eligible to receive a monthly retirement pension after age 60, providing the contributor has wholly or substantially ceased pensionable employment. Contributors are considered to have substantially ceased pensionable employment if their annual earnings from employment or self-employment do not exceed the maximum retirement pension payable at age 65 for the year the pension is claimed. On turning 65, individuals are not required to stop work and start receiving a retirement pension. People who continue to work and make contributions after age 65 may substitute periods of pensionable earnings after 65 for periods of similar length before they turned 65 when they had low or zero earnings, thereby increasing their CPP benefits.

The amount of the CPP pension benefit depends on how much, and for how long, a person contributed to the plan. In determining an individual's pension on retirement, certain periods of low or zero earnings—up to 15 percent of their contributory period—may be excluded in calculating average monthly pensionable earnings. This exclusion is intended to compensate for periods of unemployment, illness and schooling. Months of low or zero earnings while

caring for a child under the age of 7 may also be excluded from the contributory period. This provision tries to ensure that reduced earnings during childrearing years do not result in lower future pension benefits and applies to those who are eligible for the Child Tax Benefit. However, there is no parallel provision for individuals who leave the labour force during their contributory period to care for an adult with a disability.

A retirement pension payable to a person at age 65 is a monthly benefit equal to 25 percent of a contributor's average monthly pensionable earnings during that person's contributory period. The contributory period is defined as starting on January 1, 1966, or when the contributor reached 18 years of age, whichever is later, and ending when the individual takes a retirement pension or reaches age 70, whichever occurs first. Benefits are adjusted to reflect the present value of earnings in the last five years and the present value of prior earnings. In 1998, the average CPP retirement pension taken at age 65 was $408.55 per month while the maximum for that year was $744.79 per month. The maximum CPP retirement pension benefit for 2000 is $762.92 per month.

The CPP also pays a monthly pension to the surviving spouse of a deceased contributor if the contributor made sufficient contributions to the plan. The amount of the surviving spouse's pension is determined by the amount and length of time contributed to the plan, the age of the surviving spouse at the time of the contributor's death, and whether the surviving spouse is also receiving a CPP disability or retirement pension. If the surviving spouse is age 65 or older, the survivor's pension is equivalent to 60 percent of the contributor's retirement pension. In 1998, the average survivor's pension paid to persons aged 65 and over was $255.23 per month while the maximum for that year was $446.87 per month. The maximum survivor's pension for individuals over 65 years for 2000 is $457.75. The survivor's pension continues until death even if the surviving spouse remarries.

Guaranteed annual income programs

Federal and provincial governments both offer guaranteed annual income programs that benefit low-income seniors. Federal and provincial governments each determine the conditions of eligibility and the amount of benefits to ensure minimum levels of income to seniors in need.

The federal government offers the Guaranteed Income Supplement, a monthly benefit paid to OAS pensioners who have little or no other income. The amount of the GIS a person receives depends on annual income and marital status. Income includes any money other than the OAS pension that is received, such as earnings-related retirement pension, foreign pensions, interest, dividends, rents or wages. To qualify for the GIS, the annual income (excluding OAS and GIS) of a single senior cannot exceed $12,120. In the case of a senior couple, the combined annual income, excluding OAS, GIS and Spouse's Allowance (SpA) of the pensioner and spouse cannot exceed $15,792.

There are two basic rates of payment for a maximum GIS. The first rate applies to single pensioners (including widowed, divorced or separated persons) and to married pensioners whose spouses do not receive either the basic OAS pension or SpA. The maximum monthly benefit paid to single individuals is $504.05. The second rate applies to situations in which either both spouses are pensioners or one spouse is a pensioner and the other receives a

Spouse's Allowance. The maximum monthly benefit paid to married individuals is $328.32 for each spouse. If the couple are separated involuntarily, such as when one spouse is admitted to a residential care facility and the other remains at home, both pensioners are treated as single and paid accordingly at the single rate. Like the OAS pension, the GIS is indexed quarterly based on increases in cost of living, but unlike the OAS pension, the GIS is not subject to income tax. Recipients must re-apply annually for the GIS benefit.

The Spouse's Allowance is an income-tested benefit designed to recognize the difficult circumstances faced by couples living on the pension of only one spouse and by widowed persons. To qualify, an applicant must be between the ages of 60 and 64 years, must have lived in Canada for at least 10 years after turning age 18, and must be a Canadian citizen or legal resident of Canada. The SpA is paid to the spouse of an OAS pensioner whose combined annual income (excluding OAS, GIS and SpA) is less than $22,608 or to a widowed individual whose annual income is less than $16,584. The maximum benefit paid to spouses of OAS pensioners is $752.44 per month, equivalent to the sum of the full OAS pension and the maximum GIS at the married rate. The maximum amount payable to widowed individuals is $830.70. The SpA ceases when the recipient becomes eligible for an OAS pension at age 65, when the recipient leaves Canada for more than six months, when the recipient dies, when the spouses separate or divorce, when the widow/widower remarries or when income in the previous year is more than the maximum allowed. The SpA is indexed quarterly and is not subject to income tax. SpA recipients must re-apply annually for the benefit.

British Columbia: The Ministry of Social Development and Economic Security offers income assistance to all eligible residents of the province, including people age 65 or over, under the *BC Benefits Act*. The Seniors' Supplement program, which stems from this legislation, assures a minimum monthly income for single persons and couples, 65 years of age or more, who receive the federal OAS and GIS, or a couple in which one spouse receives the federal GIS and the other spouse receives the federal Spouse's Allowance. If total income from all sources falls below the level guaranteed by the province, a supplement is provided to make up the difference. The threshold income is $695 per month for a single individual and $1,082 per month for a couple. The amount of the benefit depends on income and the size of the recipient's immediate family (spouse and dependants). No application is necessary. Provincial benefits are paid automatically, based on information supplied by the Old Age Security Division, Human Resources Development Canada. The maximum amount of the monthly benefit is $49.30 for a single senior, $120.50 for a senior couple or $110.08 for a married senior whose spouse is between 60 and 64 years of age.

Ontario: The Guaranteed Annual Income Supplement for the Aged (GAINS-A) program provides a supplement to eligible low-income seniors. GAINS-A benefits are available to individuals who are age 65 years or older, receive a full or partial federal OAS pension and GIS, are permanent residents of Ontario for the last 12 months (or a previous resident for a total of 20 years after the age of 18), and have total income from all sources below the level guaranteed by the province. To qualify, the maximum annual income from private sources other than OAS and GIS must be less than $1,992 for a single individual and $3,984 for a couple. No application is necessary. Benefits are paid automatically, based on information supplied by the Old Age Security Division, Human Resources Development

Canada. The amount of benefit paid is based on reported annual income as an individual or combined annual income as a couple. GAINS-A payments range from a minimum of $1 to a maximum of $83 per month.

Nova Scotia: The Department of Community Services offers financial assistance to support needy senior citizens to enable them to remain in their own homes for as long as possible. The *Senior Citizens' Financial Aid Act* (R.S., c. 419, s.1), provides the legislative framework for this program, which includes special social assistance payments, property tax rebates and rental subsidies. Only the special social assistance payments were addressed in this policy scan as the other forms of assistance deal with housing issues. Seniors are eligible to apply for financial aid if they are residents of Nova Scotia, have either attained the age of 65 years and are in receipt of the federal OAS and the GIS, or they have attained the age of 60 years and are in receipt of the federal Spouse's Allowance. Eligibility is based on a needs test comparing household income with shelter and personal allowance up to a maximum set by the province. To qualify, the maximum monthly allowable income is $889 for single seniors and $1,285 for senior couples. Financial assets must not exceed $3,000 for single seniors or $5,500 for senior couples. Seniors' shelter expenses, such as housing, food, clothing and transportation, are based on income assistance rates plus a flat seniors rate of $175. Budget deficits are paid as special social assistance to low-income seniors.[4]

Tax deductions

The Canada Customs and Revenue Agency is involved in income security policies to the extent that the federal income tax system (which includes tax deductions and tax credits) determines taxpayers' disposable income. Indeed, the income tax system is used to redistribute income through taxes and transfers from one class of taxpayer to another. Tax deductions reduce the taxable income on which federal and provincial taxes are calculated. A tax deduction that may benefit informal caregivers economically is attendant care expenses.

The attendant care expense deduction is available only to individuals who qualify for the disability tax credit (described later). Expenses paid for attendant care may be claimed as either the attendant care expenses deduction or as a medical expenses tax credit. If attendant care expenses are claimed as a deduction, all the following conditions must be met.

- The individual claiming the deduction must be entitled to the disability tax credit.
- Expenses were paid for care in Canada so employment income could be earned.
- The attendant was not the spouse of the person who has a disability.
- The attendant was at least 18 years of age at the time payments were made.
- No one has claimed the attendant care payments under the medical expenses tax credit.

The maximum amount available for the attendant care expenses tax deduction was recently increased to $10,000 per year (or $20,000 if the individual dies during the year).

Tax credits

While tax deductions reduce the amount of tax paid by reducing the amount of income on which income tax is calculated, tax credits are applied directly against the tax payable. While there is one federal income tax credit that was designed specifically for informal caregivers, the majority of federal income tax credits were designed for others, such as individuals with disabilities or those with high medical costs. These tax credits were intended to provide tax relief to individuals to compensate for the high costs of living with disabilities or chronic health problems. Applying unused amounts from care receivers' federal income tax credits to caregivers' income tax returns may offset some of the out-of-pocket costs incurred by informal caregivers. Non-refundable federal tax credits that may affect the economic well-being of informal caregivers include the caregiver amount, the equivalent-to-spouse amount, the amount for infirm dependants age 18 or older, the disability amount and medical expenses. The allowable portion of these federal non-refundable tax credits is summed and multiplied by the lowest tax rate for the year (17 percent for 1999) to determine the total amount of federal non-refundable tax credits. This is deducted from the amount of federal tax owed. Provincial tax credits are also available to residents of British Columbia and Nova Scotia who meet certain conditions.

The federal government introduced the caregiver tax credit in the 1998 budget. The caregiver amount is a non-refundable tax credit designed to reduce the income tax owed by up to $400 for individuals who reside with, and provide in-home care for, dependent relatives. The care receiver must be a resident of Canada, 18 years of age or older, a child, grandchild, brother, sister, niece, nephew, parent, grandparent (including in-laws), aunt or uncle of the caregiver, have a net income of less than $13,853 and co-reside with the caregiver. The care receiver must also be dependent because of a mental or physical infirmity or, if a parent or grandparent (including in-laws), be born in or before 1935 and be dependent because of income. Those informal caregivers who care for relatives with incomes less than $11,500 get the maximum tax credit of $400. Those who care for individuals with incomes between $11,500 and $13,853 receive a proportionately reduced benefit. The caregiver amount and equivalent-to-spouse amount (see below) can be claimed for the same care receiver, but the caregiver amount and amount for infirm dependants age 18 or older cannot.

The equivalent-to-spouse tax credit may be claimed by individuals, such as informal caregivers, who are not married or living in a common-law relationship, and who are living with a person who is a parent or grandparent, mentally or physically infirm, related by blood, marriage or adoption. They must be co-residing in a home that the single individual maintains and living in Canada. An equivalent-to-spouse amount may be claimed, if the care receiver's net income is less than $6,290. The maximum claim for the equivalent-to-spouse amount is $5,718.

The amount for infirm dependants age 18 or older may be claimed if the care receiver meets all the following conditions:

- a parent, grandparent, brother, sister, aunt, uncle, niece or nephew, including relatives by marriage;
- born in 1980 or earlier;

- mentally or physically infirm;
- dependent on others for support; and
- living in Canada at any time in the year.

Unlike the caregiver tax credit, co-residency is not a requirement; however, the care receiver's net annual income must be less than $7,131 to qualify. The maximum amount for infirm dependent adults is $7,131. Those who care for individuals with incomes between $2,353 and $7,131 receive a proportionately reduced benefit. The benefit is further reduced if the equivalent-to-spouse amount is claimed for the same care receiver. In most cases, the amount for infirm dependants is unavailable to those who claim an equivalent-to-spouse amount for the same care receiver.

The disability amount is a non-refundable tax credit available either to individuals who have a severe and prolonged mental or physical impairment as certified by an appropriate medical practitioner, or to individuals who support dependants with such impairments. A condition is considered severe if the person's ability to perform a basic activity of daily living is markedly restricted all or almost all the time, and the impairment has lasted, or is expected to last, for a continuous period of at least 12 months.[5] Individuals who can perform the basic activities of daily living by using appropriate aids are not usually eligible to claim the disability amount.

A spouse or "supporting individual" may be able to claim unused portions of the disability amount that the person with the disability does not use to reduce her/his own federal income tax payable to zero. Any unused portion of the disability amount may be transferred if one of the following conditions apply:

- an equivalent-to-spouse amount is claimed for that care receiver;
- the care receiver is a parent or grandparent (including in-laws), and an equivalent-to-spouse amount for that dependant could have been claimed if the caregiver had no spouse and the care receiver had no income; or
- the care receiver is a parent or grandparent (including in-laws), and an amount for infirm dependants age 18 or older could have been claimed if the care receiver had no income. In addition, the care receiver must have a mental or physical infirmity.

A supporting person can claim the unused part of the disability amount only if the spouse of the person who has a disability is not already claiming the disability amount or any other non-refundable tax credit (other than medical expenses) for the care receiver. The disability amount is calculated by multiplying the lowest personal tax rate by a fixed amount. This predetermined amount may be increased from one taxation year to the next, each time there is an annual indexation adjustment. For 1999, the disability amount was 17 percent of $4,233 or $720.

The medical expenses tax credit is a non-refundable tax credit for individuals who have sustained significant medical expenses for themselves or certain dependants who relied on them for support. Dependants may include a spouse, parent, grandparent, brother, sister, uncle, aunt, niece or nephew (including in-laws), who lived in Canada at any time in the

year. To qualify for the medical expenses tax credit, the medical expenses must have been paid, or deemed to have been paid, by either the care recipient or her/his legal representative for qualifying medical expenses incurred within any 12-month period ending in the calendar year.

Qualifying medical expenses are amounts paid to a medical practitioner, dentist, nurse, or public or licensed private hospital for medical or dental services provided. They can also include the purchase price or, where applicable, the rental charge or other expenses (e.g., maintenance, repairs, supplies) related to devices and equipment as listed in the *Income Tax Regulations*. An amount paid for a device or equipment cannot be claimed unless the device or equipment is listed in the Regulations and prescribed by a medical practitioner. Such devices include artificial limbs, wheelchairs, crutches, hearing aids, prescription eyeglasses or contact lenses, dentures, pacemakers, prescription drugs and certain prescription medical devices. Expenses for guide and hearing-ear dogs also qualify as medical expenses. If medical treatment is not available locally, the cost of traveling to receive the treatment somewhere else may be claimed. Reasonable expenses for renovations or alterations to an individual's dwelling may also be claimed as medical expenses, if the expenses enable the individual to gain access to a dwelling, or be mobile or functional within it. Included in this category are reasonable expenses for structural changes, such as ramps, enlarging halls and doorways or expenses to move an individual to housing that is more accessible (to a limit of $2,000).

Paid care by formal caregivers may qualify as either the attendant care tax deduction or a medical expenses tax credit for a given care receiver. There is no limit on the amount of attendant care expenses that can be claimed under the medical expenses tax credit, in contrast with the $10,000 ceiling when such expenses are claimed as an attendant care tax deduction. All amounts paid for attendant care may be claimed as a medical expense if a doctor or other medical practitioner certifies that the care receiver is dependent on others for care due to a long-term mental or physical infirmity. This pertains to either institutional care or care at home by an attendant who was not a spouse of the care receiver and who was 18 years of age or older when the amounts were paid.

The medical expenses tax credit is a function of the actual eligible expenses incurred, the taxpayer's income and the care receiver's income. The amount of eligible medical expenses is first reduced by either $1,614 or three percent of the taxpayer's net income for the year, whichever is less. It is further reduced by an amount that is the care receiver's net income in excess of $7,044, multiplied by four. To claim medical expenses as a non-refundable tax credit, the adjustment based on the incomes of the taxpayer and care receiver cannot exceed the medical expenses paid.

British Columbia and Nova Scotia each have one tax credit that may reduce the amount of income tax owed by care receivers thereby increasing their disposable income which, in turn, has the potential to reduce the amount of out-of-pocket expenses informal caregivers may incur. In British Columbia, provincial income taxes are reduced by $50 for each dependant for individuals who have claimed a spousal amount, an equivalent-to-spouse amount or an amount for infirm dependent adults on their income tax returns. Only one person can claim a tax reduction for a given dependant. In Nova Scotia, an income tax

reduction is available to residents of Canada with low net family incomes who meet any of the following conditions:

- 19 years of age or older;
- have a spouse; or
- are a parent.

For those who are married, only one person may make the claim for themselves, their spouse and their dependants. The basic reduction is $300. An additional $300 may be claimed for a spouse or if an equivalent-to-spouse amount is claimed. The basic tax reduction (or sum of the basic plus spouse and dependent children amounts) is then decreased by five percent of net family income in excess of $15,000.

Summary of income security policies

Table 2 provides an overview of the income security programs available across jurisdictions. While the federal government administers pension plans, guaranteed annual income programs, and tax credits and deductions, provincial governments administer social assistance programs and guaranteed annual income programs. Eligibility for income security programs is determined primarily by care receiver characteristics, although many of the federal income tax deductions and credits include two caregiver–care receiver dyad characteristics: relationship and proximity. Social assistance programs may replace a portion of the employment income of informal caregivers who leave the labour force to provide elder care. Pension and guaranteed annual income programs provide seniors with current income with which to meet basic needs. In theory, if seniors have adequate income, they are more likely to pay for their own supplies and services rather than pass these out-of-pocket expenses on to informal caregivers. Federal income tax deductions and tax credits may also offset the out-of-pocket expenses of care receivers or informal caregivers, if they meet the strict eligibility criteria.

Table 2. Summary of the Availability of Income Security Programs across Jurisdictions

Income Security Programs	Federal Government	British Columbia	Ontario	Nova Scotia
Social assistance		✔	✔	✔
Old Age Security	✔			
Canada Pension Plan	✔			
Guaranteed annual income programs	✔	✔	✔	✔
Income tax deductions and credits	✔	✔		✔

Labour Programs

Both the federal and provincial governments have the power to enact labour laws. Judicial interpretations of the relevant sections of the *Constitution Act* give provincial legislatures

major jurisdiction. Federal jurisdiction is limited to occupations that are of a national, international or interprovincial nature, and works that are "for the general advantage of Canada or for the advantage of two or more of the provinces" (HRDC 1996). The *Canada Labour Code* is the federal legislation which outlines standards for industrial relations (Part I), occupational safety and health (Part II), and standard hours, wages, vacations and holidays (Part III). The *Canada Labour Code* applies to employees of federally regulated industries (e.g., banking, telecommunications, transportation, grain elevators, uranium mining and processing, and the protection and preservation of fisheries as a natural resource) and to activities that connect one province to another such as railways, highway transport, pipelines, air transport, canals, ferries, tunnels and bridges, marine shipping, and telephone and cable systems.

Family responsibility leave

In British Columbia, the Ministry of Labour, Employment Standards Branch, is responsible for administering the *Employment Standards Act* and Regulations, the legislation that specifies the minimum standards to which employees in British Columbia are entitled. Part 6 of the Act entitles employees[6] to certain types of unpaid leave from work while protecting their job, work conditions and benefits. Family responsibility leave is an entitlement designed to help employees deal with family problems that conflict with job responsibilities. Under section 52 of the Act, employees are allowed to take up to five days of unpaid leave each year, to meet responsibilities related to the care, health or education of a child in the employee's care, or the care or health of any other member of the employee's immediate family (spouse, child, parent, guardian, sibling, grandchild or grandparent) or any person living with the employee as a member of the employee's family. The employee is granted leave on request. For the purposes of this section of the Act, any time taken on a day constitutes one day of unpaid leave, unless the employer and employee agree otherwise. Employers are free to grant additional leaves at their discretion. Family responsibility leave does not carry over from year to year.

The Ontario *Employment Standards Act* and *Employment Standards Regulations*, the Nova Scotia *General Labour Standards Code Regulations*, as well as the federal *Canada Labour Code* do not have comparable clauses for family responsibility leaves that may benefit informal caregivers who are employed.

Summarizing the Policy Scan

We gathered information on the policy milieu that may affect, directly or indirectly, the economic status of informal caregivers. Relevant health, income security and labour programs were summarized in each policy domain.

Overall, the majority of programs reviewed were intended for care receivers rather than informal caregivers. Eligibility for health and income security programs was based largely on care receiver characteristics, although some programs, such as home care and federal income tax deductions and credits, depended on caregiver–care receiver dyad characteristics such as relationship, proximity and availability of informal caregivers to assist (see Appendix E). The user fees charged by various health care programs may increase the out-of-pocket expenses of seniors and their informal caregivers in circumstances where seniors

are unable to pay for these costs. Pension programs and guaranteed annual income programs affect the adequacy of seniors' income with which to pay for basic needs. Tax deductions and tax credits that can be claimed by caregivers because of their status as a caregiver have the potential to increase their disposable income, thereby offsetting some of the financial costs of caregiving and compensating for the unpaid work of caregiving. Alternatively, those tax deductions and credits claimed by care receivers can increase their disposable income, enabling them to meet their own expenses and, therefore, reducing the out-of-pocket costs passed on to informal caregivers.

In comparison, eligibility for labour programs, specifically family responsibility leave, is based on caregiver and dyad characteristics, such as employment status and relationship. While family responsibility leave is unpaid, such legislation is likely to protect the employment-related benefits and future income of informal caregivers by ensuring the security of their jobs. If eligibility criteria are met, provincial social assistance programs may replace a portion of the employment income of informal caregivers who leave the paid labour force to provide unpaid elder care. Regardless, any reduction in the current income of informal caregivers is likely to affect their future pension income under the Canada Pension Plan.

In the next chapter, we examine the short- and long-term economic impacts of public programs, including the differential impact of caregiver and regional characteristics on the economic status of informal caregivers. In addition, we present the policy analysis framework that identifies those characteristics that moderate the economic impact of programs on informal caregivers.

3. ANALYSIS OF THE ECONOMIC IMPACT OF POLICIES ON INFORMAL CAREGIVERS

Thus far, we have provided the background information necessary to meet the first objective of the project by describing economic costs, regions, caregiver profiles, and federal, provincial and regional health, income security and labour programs. In this chapter, we build on this foundation by describing our analysis of the short- and long-term economic impacts of health, income security and labour programs on different types of informal caregivers who live in different regions of Canada. Particular attention was given to the differential impact of programs on women and men caregivers. We examine the economic impact of 21 different programs for each of six caregiver profiles living in each of three regions (see Appendix F for summary tables). Further, we present the policy analysis framework that was refined through the process of conducting our own analysis of the economic impact of a variety of public programs on informal caregivers.

In the first section, we provide a broad overview of the impact of programs (within the domains of health, income security and labour) on the types of economic costs (lost current and future income, lost employment benefits, out-of-pocket expenses and unpaid labour) that might be incurred by informal caregivers. We note that programs within some of the domains of interest most likely affect certain types of costs. In the second section, we provide a more detailed examination of how characteristics of caregivers, regions and program eligibility might moderate the impact of programs on costs. In the third section, we discuss programs that have an insignificant economic impact on informal caregivers. In the final section, we present the revised policy analysis framework.

Impact of Programs on Economic Costs

Of the programs reviewed, most have the potential to affect the out-of-pocket costs of informal caregivers. Health programs, such as home care, adult day programs and home oxygen programs, charge user fees for services that may add to the out-of-pocket costs of informal caregivers. For example, home care programs charge fees for home support services and, often, for assistance with personal care. Fees are based on the care receiver's income and family size, and overall expenditures may vary with the frequency of service. In circumstances where care receivers are unable to afford such services, informal caregivers may assume the costs of care, thereby adding to caregivers' out-of-pocket expenditures. Other programs may reduce caregivers' out-of-pocket expenses by subsidizing health care supplies and services. For example, drug plans subsidize the cost of some pharmaceuticals, while income tax deductions and tax credits for medical expenses (such as equipment, attendant care and renovations to accommodate continued community living) may reduce tax liability, thus increasing disposable income. We speculate on the extent to which out-of-pocket expenses, such as these, may be offset by programs that benefit informal caregivers financially.

Few programs have an impact on the employment-related costs of informal caregivers. Within labour policies, the family responsibility leave program may reduce the current income of informal caregivers if they take more days off without pay than they would

without the benefits of the program. Regardless of the time taken, the family responsibility leave program protects the future income and employment benefits of employed informal caregivers by offering them job security. However, this type of program is available only to those who are employed and only in a few jurisdictions. Income security policies, such as social assistance programs, may partially replace the incomes of informal caregivers who relinquish their paid employment to provide unpaid elder care, but only if they have no other sources of income or assets. Any decisions which reduce current income, for example by reducing hours of paid employment or postponing or declining job training and promotions, will have lasting effects on future income in retirement. Pension income from the Canada Pension Plan, as well as employer pension plans, is inevitably reduced because earnings and the length of service on which pensions are based are reduced. The impact of policies on caregivers' current and future income are likely to be significant.

Public programs also influence the unpaid labour provided by informal caregivers. Within the domain of health policies, home care and adult day programs may relieve informal caregivers of some of their responsibilities by providing formal services to the care receiver, such as assistance with bathing. While home care policies are intended to supplement the efforts of individuals to care for themselves with the assistance of family and friends (B.C., Office for Seniors 1999; Home Care Nova Scotia 1997; Ontario, Ministry of Health 1999), there is evidence that formal services complement, rather than substitute for, the care provided by informal caregivers. After completing a systematic review of studies on relationships involving self-, informal and formal care published from 1985 through 1998, Penning and Keating (2000) concluded that informal caregivers do not cease or reduce, in a substantial or continuing way, their involvement in the provision of care when formal community-based services are available. While policies are unlikely to reduce unpaid labour in any significant way in the short term, informal caregivers may provide more elder care in the long term, because they are able to sustain their involvement longer with support from the formal care sector.

Table 3 provides an overview of the impact of broad policy domains on the economic costs to informal caregivers. As discussed in this section, specific programs within each domain may have a positive or negative impact on costs, or may be neutral in their outcome. The economic impact of policies is moderated by characteristics of caregivers and regions. In the next section, we explore these characteristics in detail.

Table 3. Summary of Impact of Programs by Policy Domain on Economic Cost

Type of Program	Type of Economic Cost				
	Lost current income	Lost future income	Lost employment benefits	Out-of-pocket expenses	Unpaid labour
Health programs				✔	✔
Income security programs	✔	✔		✔	
Labour programs	✔	✔	✔		

Factors that Moderate the Economic Impact of Programs

The degree to which programs have an economic impact on caregivers may be influenced by characteristics of informal caregivers, care receivers or the regions in which they live. Thus, these contextual factors moderate, or affect the magnitude of, the impact of programs on the economic well-being of informal caregivers. We begin with an overview of the methods used to identify these moderating characteristics followed by detailed illustrations of how these characteristics differentially affect the relationship between a given program and its economic impact on informal caregivers.

Caregiver profiles, presented in Chapter 2, were based on six characteristics deemed to be important predictors of caregiver consequences. In our impact analysis, we found that four attributes of caregivers stood out as particularly important in moderating the impact of programs on caregiver costs. These are gender, presence of young children, labour force status and geographic proximity. Similarly, of the six regional factors identified by consultants, the local economy, as reflected in income level and unemployment rate in the region, was the main regional characteristic that moderated the economic impact of programs. Among the 13 eligibility criteria for the health, income security and labour programs reviewed, income of care receivers moderated the relationship between some programs and out-of-pocket costs of informal caregivers.

These caregiver and regional characteristics, and eligibility criteria interact with each other, making the impact analysis particularly complex. Because differences between women and men caregivers often interact with moderating characteristics, such as presence of children and labour force status, gender differences are woven throughout the following discussion.

Presence of Young Children

The presence of young children moderates the effect of labour programs, especially family responsibility leaves, on lost current and future income. For informal caregivers, the presence of young children represents a competing demand with frail seniors for caregivers' time and attention. Both women and men caregivers who had children under 15 years have been shown to make more job adjustments and provide fewer hours a week of care than those without young children (Keating et al. 1999). Similarly, employees with dual elder and child-care responsibilities reported the highest incidence of missing partial or full days of work (CARNET 1993; Neal et al. 1993). Multiple caring demands, such as caring simultaneously for an elderly individual and children, or caring for more than one elderly person, are also correlated with postponed economic opportunities, such as taking on extra projects, going on business trips and further education (CARNET 1993; Gottlieb et al. 1994).

Informal caregivers, like Rebecca and Rob, who have children under 15, are at greater risk than those who do not have young children, of having reduced current income, if their pay is reduced when they are tardy or absent from work because of elder-care responsibilities. On the other hand, employed caregivers, who take advantage of unpaid family responsibility leaves, have job security and protection of future income and employment benefits. Of the three provinces surveyed, the family responsibility leave is available only in British Columbia. Our analysis of the 1996 General Social Survey suggests that over 70 percent of employed

caregivers in British Columbia are caring for individuals in their "immediate family" and thus are eligible for the family responsibility leave.

When compared to men, women are more likely to take time off from paid employment or reduce paid employment to deal with family responsibilities (Fast and DaPont 1997). Therefore, women are more likely than men to benefit from family-friendly labour policies, such as the family responsibility leave program in British Columbia, providing they can meet their dual family responsibilities of child and elder care within the allotted five days per calendar year. In the short term, people with younger children are more likely than caregivers without young children to take days off, and more likely to take the full five days off, without pay because they have greater family demands to meet. This loss of current income by caregivers with young children may have a greater proportional impact on their family income at a time when they can least afford it. In fact, the poverty rate has risen over the last two decades among the working-age population, most dramatically for families headed by younger people (CCSD 2000b; Ross et al. 2000). Poverty rates among lone-parent families headed by women, Aboriginal peoples, persons with disabilities and members of visible minorities remain high (Ross et al. 2000).

Labour Force Status

Labour force status moderates the effect of labour (family responsibility leave) and income security policies (Canada Pension Plan and attendant care expenses tax deduction) on lost current income, lost future income and out-of-pocket costs. As with presence of children, labour force participation represents a competing demand for informal caregivers' time and attention (Fast and Mayan 1998; Keating et al. 1999).

Many informal caregivers are employed. Almost three quarters of men and about half of women caregivers were employed full time in 1996 (Keating et al. 1999). When compared to men, women are less likely to be employed in positions that provide flexibility in work schedules or place (Fast and Frederick 1996). In 1998, 41 percent of employed men 30 to 44 years of age had flexible work schedules compared with 33 percent of women the same age (Statistics Canada 1998a). Similarly, 43 percent of employed men 45 to 64 years of age had flexible work schedules compared with 31 percent of women the same age. Few employees had flexible work places. Only 17 percent of women 30 to 64 years of age, 19 percent of men 30 to 44 years old and 24 percent of men 45 to 64 years of age usually worked some of their scheduled hours at home. Thus, labour policies that enable informal caregivers to balance work and family obligations without jeopardizing their employment status are more likely to benefit women than men caregivers. As discussed above in relation to the presence of young children, family responsibility leaves may reduce the current income of those who take advantage of the program while protecting their future income and employment benefits. Based on the 1996 General Social Survey, 1.4 million informal caregivers may be affected by employment standards legislation. However, family responsibility leave programs do not benefit many employed informal caregivers because such programs are not very prevalent. Only two provinces provide family responsibility leave programs that enable employees to balance work and family responsibilities; only one province recognizes the care provided by families to members other than children (HRDC 1997a). While the definition of "immediate family" used in the British Columbia family responsibility leave program is fairly broad, it excludes care provided to extended family members (such as aunts, uncles, cousins) and

friends. In a national survey of informal caregivers, Fast et al. (1999a) found that almost five percent were caring for extended family and 19 percent were caring for non-kin.

For employed informal caregivers who purchase attendant care rather than reduce involvement in the labour force, expenditures (up to $10,000 per year or $20,000 in the year in which the care receiver dies) may be used as a tax deduction. Attendant care expenses may be claimed by employed caregivers to reduce the income on which federal income taxes are calculated. The attendant care expenses tax deduction is more likely to be claimed by individuals who have higher incomes or greater amounts of disposable income who can afford to hire private attendant care while they are at work. Men have higher incomes than women (Statistics Canada 2000), therefore, men are more likely than women to be able to afford attendant care so they can work, thereby increasing their out-of-pocket costs rather than sacrificing their current and future income.

Part-time employment is a strategy to meet competing paid work and family demands (Logan 1994). Women are at greater risk than men of reduced current income and future pension income because of their greater propensity to decrease or cease paid employment in order to care for family members (Fast and DaPont 1997). This is particularly true for older women caregivers, like Joan, who considers leaving the labour force to care for her ailing parent. Both reductions in employment (from full to part time) and withdrawal from the labour force result in reduced current income, reduced future income and loss of employment benefits. Informal caregivers who find themselves without employment benefits, such as extended health and dental coverage, life and disability insurance, and employer-provided pensions, because they reduced or forfeited paid employment to provide elder care may incur significant costs in order to regain these benefits, over and above their lost income. For women caregivers who reduce their hours of paid employment, there are no public programs in the regions surveyed which counteract the loss of current and future income,[7] or the potential loss of employment benefits.

Using our case studies as examples, women caregivers who relinquish their paid employment for unpaid elder care may give up $15,000 to $26,000 annually in current income. This lost income does not include employment benefits, such as employer pensions, health and dental benefits, or disability and life insurance coverage. For these women caregivers, two programs may offset their lost current income. First, social assistance programs, with a waiver of mandatory job placement, and training requirements of provincial “welfare-to-work” policies may provide caregivers who have no other sources of income and assets with some income with which to meet basic needs. Given that 66 percent of women caregivers and 74 percent of men caregivers were married (Keating et al. 1999) and our case profiles have annual household incomes of $42,000 to $69,000, it seems highly unlikely that many married caregivers would qualify for social assistance. For caregivers who are single, the situation may be somewhat different. One of our consultants spoke of two examples in which single men on social assistance were the primary caregivers of elderly relatives. In both cases, these men were being pressured by social service agencies to seek employment on an active basis. If these men gave up their caregiving responsibilities for paid employment, it would cost the public sector more in institutional care for the seniors than was being paid in social assistance. Second, under the attendant care tax deduction, individuals can be paid for attendant care, providing they are not the spouse of the person who has the disability. Using our caregiver profiles as examples, if Joan left paid employment, Joan’s husband could pay her to provide

care to her widowed mother-in-law so he could work, thereby relieving himself of elder-care responsibilities. While the current income of Joan and her husband would be reduced because she left the paid labour force to provide unpaid elder care, their household income could benefit from a reduction in taxable income. It is important to note that the value of a tax deduction varies according to level of income. Tax deductions are worth considerably more to a taxpayer with a high income who pays tax at a top rate than to a person who has less income and pays tax at a lower rate. In any case, the benefits provided by either social assistance programs or income tax deductions in no way fully compensate for caregivers' lost employment income.

In the long term, the loss of current income experienced by women caregivers who reduce or cease paid employment to provide elder care may jeopardize their future income. The Canada Pension Plan bases retirement income on the amount contributed to the plan and the length of an individual's contributory period. If paid employment is reduced, the amount contributed to CPP is also reduced. If paid employment is forfeited, then both the amount contributed to CPP and the length of the contributory period are reduced. While there is a drop-out provision in the CPP program of seven years for raising children (HRDC 1997b), there is no equivalent clause for the provision of elder care. Low income during the working years is one of the best predictors of poverty in old age (Ross et al. 2000). Thus, current programs, such as social assistance and CPP, likely perpetuate the poverty of older women.

Geographic Proximity

The caregiver tax credit was specifically intended to reduce the amount of income tax owed by informal caregivers who reside with, and provide in-home care for, infirm dependent adult relatives. None of the profiled caregivers was eligible for this non-refundable tax credit since spouses are ineligible and few other caregivers live with the person for whom they provide care. In the 1996 General Social Survey, only six percent of informal caregivers were relatives other than spouses who lived with the care receiver. This proportion of caregivers would be considerably reduced by virtue of the care receiver's income test of $13,853 per year. Because the average annual income of Canadians over 65 was $16,070 for women and $26,150 for men in 1997, and the incomes of both senior women and men are rising (Lindsay 1999), few caregivers will benefit from the caregiver tax credit. Among those few who may be eligible, the economic benefit of $400 is meagre when compared with the economic costs of living with, and providing 24-hour care to, a frail senior.

Informal caregivers like Rebecca, Rob, Joan and John who do not reside with their care receivers, provide in-home care and assistance that enables care receivers to remain in their own homes in the community, thereby delaying facility care which has greater costs to the public sector. While women and men caregivers who reside with a senior may spend more time providing care, those who experience the greatest socio-economic impact live within commuting distance of their care receivers (Keating et al. 1999). Both women and men caregivers living less than a half day away from the care receiver were more likely to experience socio-economic consequences, such as changed social activities, holiday plans, sleep patterns or extra expenses than were those living with the elder. Thus, commuting time involved for these caregivers encroached on time available for social activities, recreational pastimes and sleep. Commuting caregivers also incur out-of-pocket expenses for transportation, such as gas, insurance, vehicle maintenance and depreciation. While

these caregivers live close enough to help, they are ineligible for the caregiver tax credit that has the potential to ameliorate, at least in part, their socio-economic consequences.

Moreover, geographic proximity plays a role in employee tardiness, absenteeism, poor job performance and the need to reschedule paid work to accommodate caregiving at a distance. Men who lived within several hours of the person for whom they cared made significantly more job adjustments and felt more burden than men who lived in the same household or building as the senior (Keating et al. 1999). This same effect was not true for women, however, as employed women caregivers are more willing to travel farther, more often, to provide elder care than employed male caregivers (Joseph and Hallman 1998). Women caregivers are more likely than their male counterparts to take on more travel and try to compress more into already tight schedules. Thus, employed women and men caregivers living within commuting distance of their care receivers may have a greater reliance on family responsibility leave programs than employed caregivers who live closer to the care receiver. While current income may be affected by adjusting work schedules to accommodate elder-care responsibilities, a family responsibility leave program could provide job security thereby maintaining caregivers' future income and employment benefits.

Income of Care Receivers

The income of care receivers moderates the effect of income security program eligibility and other means-tested programs. While poverty rates among seniors have dropped over the last two decades (CCSD 2000b), poverty among unattached senior women remains high. Elderly women are more likely than other population groups to be poor (CCSD 2000a). In 1997, 49 percent of Canadian unattached women over the age of 65 were living in poverty compared to 33 percent of elderly unattached men (Ross et al. 2000). Researchers caution that while the poverty rate among seniors has improved, "a large segment of the non-poor are nearly poor" (Ross et al. 2000: xx). Care receivers' income determines eligibility for, and the level of, benefits available from pensions, guaranteed annual income programs, tax deductions and tax credits. The income of care receivers is also salient in moderating the effect of health programs, such as home care and drug plans, on the out-of-pocket expenses of care receivers and their informal caregivers. As will be shown, health programs, such as home care and drug plans, that waive user fees for low-income seniors and programs that subsidize the cost of expensive equipment may address some of the out-of-pocket expenses of caring for low-income seniors. However, it appears that many income tax deductions and tax credits do not.

Care receivers with adequate income are more likely to be able to meet their own out-of-pocket expenses, than are low-income care receivers who may be unable to afford necessary supplies and services. The cost for these basic necessities may then be absorbed by their informal caregivers. Pension programs, such as Old Age Security and the Canada Pension Plan, provide care receivers with modest income which is often inadequate to meet basic needs. This base amount may be supplemented by federal and provincial guaranteed annual income supplement programs for low-income seniors who qualify. In our caregiver profiles, married care receivers had modest family incomes of $32,851 to $55,022 based on OAS, CPP and personal savings. In contrast, widowed care receivers had substantially lower incomes. In our policy impact analysis, more health and income security programs were available to unattached, low-income care receivers. Using our case studies as an example, a widowed elderly woman living in rural

Cape Breton has an annual income of $13,291, primarily derived from OAS, GIS and a CPP survivor benefit. Because of her low income, she qualifies for the Nova Scotia Low Income Tax Reduction of $300, a waiver of monthly fees of $60 for the Nova Scotia Home Care or Home Oxygen Program, and a reduction of the annual premium of $215 for the Nova Scotia Pharmacare Program. When she lived with her husband, their household income of $32,851 made them ineligible for these subsidies, paying $935 annually in out-of-pocket expenses for home care and Pharmacare alone. Thus, individuals who care for lower-income care receivers would likely, in the absence of these health care subsidies and income support programs, be absorbing more of the care receiver's out-of-pocket expenses for basic necessities. However, they may still absorb the cost of extraordinary health care needs of care receivers such as prostheses, wheelchairs and hearing aids.

The cost of equipment necessary to support independent community living is often substantial and may be difficult for low-income seniors to afford. While equipment subsidy programs reduce the cost of such equipment, these programs are rare. Of the regions surveyed, only Ontario had an assistive device program that financially assists people with long-term physical disabilities to obtain basic, competitively priced equipment appropriate for individuals' needs and lifestyle. For example, the Ontario Assistive Device Program may contribute $500 per hearing aid every three years toward its purchase price. In other regions, care receivers must bear the full cost of purchasing equipment. Extraordinary expenditures on equipment are more likely to be made by informal caregivers than by low-income care receivers who barely subsist.

Federal tax deductions and tax credits, such as the amount for infirm dependent adults, may be available to informal caregivers who care for low-income seniors and who meet eligibility criteria. Benefits from these programs may help reduce some of the out-of-pocket costs these caregivers bear. For example, the amount for infirm dependent adults is available to caregivers, if the annual income of the person for whom they are caring is less than $7,131. Unlike the caregiver tax credit, co-residency is not a requirement. Similarly, the medical expenses tax credit takes into account care receiver income. The amount available to caregivers for the medical expenses tax credit is reduced if the annual income of the care receiver is more than $7,044. While these tax deductions and credits may offset some out-of-pocket expenses incurred by informal caregivers, it seems highly unlikely that many care receivers would meet the income cut-offs. Contrary to expectation, these tax deductions and credits are unlikely to reduce the economic impact on caregivers of caring for low-income seniors, except those who are caring for severely impoverished seniors.

Regional Economy

The economy of a region, as reflected by average resident income and the unemployment rate, moderates the effect of health programs, such as home care, on the out-of-pocket expenses and unpaid labour of informal caregivers.

As described earlier, there are significant differences in the economy across the selected regions in our study. The regional difference in income level for individuals of the same age group and gender ranges from $7,588 to $15,335. The Capital Regional District of British Columbia has the highest income levels, while rural Cape Breton consistently has the lowest income levels for both men and women. Similarly, the unemployment rate for the Capital Regional District and the Niagara Regional Municipality are eight percent—below the

national average of 10 percent and considerably lower than the average unemployment rate of 29 percent in Cape Breton.

Informal caregivers living in more economically challenged regions that have lower average incomes and higher unemployment rates may have greater economic burdens compared to caregivers in more prosperous regions. Caregivers may struggle to balance work and family responsibilities without jeopardizing their employment status. Our consultant from Cape Breton stated that there is increased pressure on women to retain their employment because of the job losses of spouses (or expected job loss with seasonal work). In fact, the incomes of female spouses continue to play a key role in sustaining families (Ross et al. 2000). Thus, women may be expected to juggle child care, elder care and employment responsibilities. Caregivers may also struggle to make ends meet and to incur out-of-pocket expenses associated with elder care. Our regional consultant stated that many individuals of working age, particularly men, are unemployed because of the elimination of particular industries. Consequently, caregivers often do not have enough money for the major out-of-pocket expenses for those they are caring for, such as medical equipment and renovations. Further, she is aware of situations in which high unemployment has led many seniors to move into the homes of their adult children to increase the caregivers' family income. This situation may lead to higher stress levels and extra demands on financial resources. However, adult child caregivers in this situation often are reluctant to consider institutional care for their parent despite their feelings of burden because "when mom or dad leaves, the income goes as well."

Finally, caregivers may struggle to meet the needs of their care receivers in areas where there are few formal resources. The economy of a region affects its ability to provide formal services or attract private sector service providers. For example, fewer health care services were available in rural Cape Breton compared to the Capital Region and the Niagara Region. Adult day programs and consultation services of allied health professionals, which may support the independence of community-dwelling seniors and their informal caregivers, were not available in rural Cape Breton. Often, distance exacerbates the limited availability of formal services. Care receivers requiring specialized health care services, such as rehabilitation, either forego the service or travel great distances, at their own expense, or at the expense of their informal caregivers, to obtain such health care services. These same health care services are often available in more densely populated or economically prosperous regions.

Programs with an Insignificant Economic Impact on Informal Caregivers

Our analyses showed that most income tax credits and deductions have little economic benefit to many informal caregivers.

The medical expenses tax credit is intended to offset the out-of-pocket expenses of individuals who have sustained significant medical expenses for themselves or certain dependants who relied on them for support. The benefit derived is based on income relative to the expense incurred. We used the caregiver profile of Joan living in rural Cape Breton as an example in estimating the economic impact of the medical expenses tax credit on the

out-of-pocket expenses of informal caregivers, particularly those who can ill-afford high medical expenses. As shown in the box, it was assumed that Joan spent $2,000 on eligible medical expenses. From this amount, three percent of her annual income is deducted. Because the medical expenses are for a dependant other than a spouse, Joan's claim is further reduced by four times the care receiver's income ($13,291) in excess of $7,044 (4 x $6,247). Based on these calculations, Joan is unable to claim any of the medical expenses she paid to support her mother's care. If her mother's annual income was less than $7,044, then Joan could claim $258.17 as a non-refundable medical expenses tax credit (17 percent of $1,518.62). Thus, it appears that the medical expenses tax credit, which is based on expenditures relative to both caregivers' and care receivers' incomes, provides little benefit to non-spouse caregivers, unless their care receiver is destitute. To spouse caregivers, the medical expenses tax credit provides a modest benefit. In our case studies, which used a constant of $2,000 in medical expenses, approximately 8 to 14 percent (11 percent on average) of these out-of-pocket costs were recouped by spouse caregivers.

Medical expenses	$ 2,000.00
Minus: $1,614 or three percent of caregiver's net income, whichever is less	$ 481.38
Subtotal	$ 1,518.62
Minus: Medical expenses adjustment (based on four times the care receiver's income in excess of $7,044)	$24,988.00
Allowable portion of medical expenses	nil

Other tax credits are available primarily to care receivers rather than caregivers. Typically, care receivers must reduce or eliminate their own household tax payable first before unused amounts from tax credits, such as the disability tax credit or medical expenses tax credit, are passed to informal caregivers. In some cases, the ability to transfer tax credits from a care receiver to an informal caregiver is complicated by other eligibility criteria, such as relationship factors and other tax deductions or credits claimed. For example, unused portions of the disability tax credit may be transferred "if the care receiver is a parent or grandparent (including in-laws) and an equivalent-to-spouse amount for that dependent could have been claimed if the caregiver had no spouse and the care receiver had no income" (Revenue Canada 1998). Similarly, the caregiver tax credit is affected by the care receiver's income in excess of $11,500 and the equivalent-to-spouse amount claimed for the same care receiver. These examples typify the entanglements of conditional clauses in the income tax system. Based on our case study analyses, informal caregivers met some of the eligibility criteria for most tax deductions and tax credits, but rarely all of them.

In summary, many policies affect the economic well-being of informal caregivers by affecting their out-of-pocket costs, current and future employment earnings and benefits, and amount of unpaid labour. Type of economic cost varies across policy domain. Characteristics of informal caregivers, care receivers and regions moderate the degree to which programs have an

economic impact on caregivers. These factors are gender, presence of young children, labour force status, geographic proximity, income of care receiver and regional economy, as reflected in income level and unemployment rate. While many policies have an economic impact on informal caregivers, some, like the caregiver tax credit and other income tax credits, provide little economic benefit to informal caregivers. In the next section, we present the policy analysis framework that can be used with any policy instrument, to determine the economic impact of a given policy instrument on informal caregivers. As illustrated thus far, applications of the framework have identified the potential poverty informal caregivers may face, gender inequity arising from specific policy instruments and regional differences in the economic impact of public policies. In Chapter 4, policy recommendations are provided to address these issues.

Policy Analysis Framework

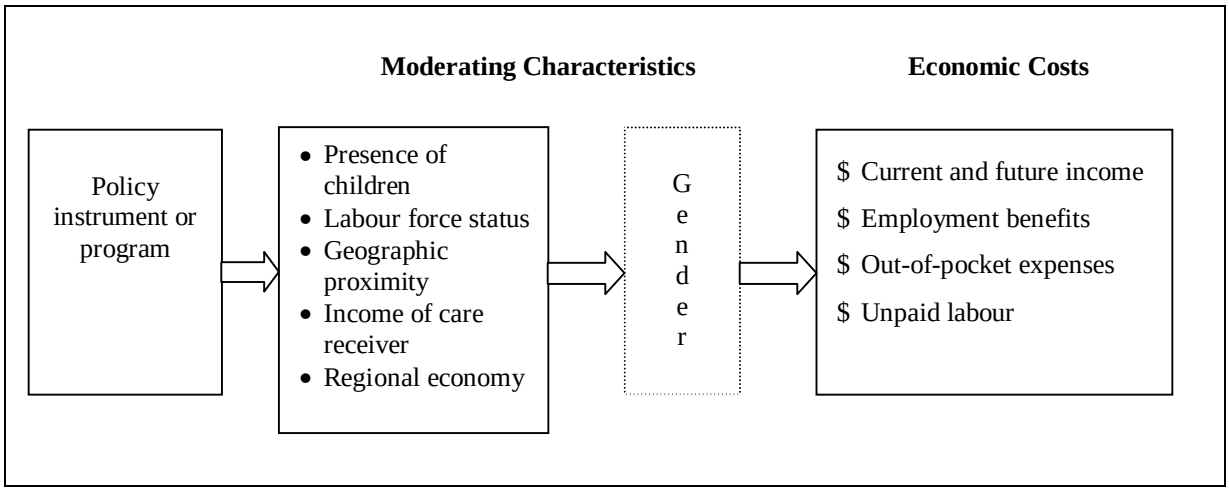
The second objective of this project was to develop a framework to evaluate the economic impact of national, provincial and regional policies on informal caregivers of frail seniors. In our second interim report to Status of Women Canada (March 27, 2000) we presented a draft of the policy analysis framework. In April 2000, the draft policy analysis framework was shared with individuals from the Federal/Provincial/Territorial Committee of Officials (Seniors), the Home Care and Pharmaceuticals Division of Health Canada, the Social Policy Division of Human Resources Development Canada, the Social Policy Division of the Department of Finance, and Status of Women Canada. Examples of the economic impact of specific programs on informal caregivers were provided and feedback was solicited.

In applying this initial framework to analyze the economic impact of policies on informal caregivers, characteristics of caregivers, care receivers and regions that made a difference to the economic well-being of informal caregivers, and those that did not, became apparent. In this section, we describe the four components of the refined policy analysis framework (see Figure 1): a given policy instrument or program, characteristics that moderate the effect of any given policy on economic costs, gender of the caregiver as a particularly important moderating characteristic and types of economic costs.

Policy Instrument or Program

The first component of the policy analysis framework is the policy instrument or program itself. In Chapter 2, we described the intent, eligibility criteria, user fees and benefits of various health, income security and labour programs that may have had an economic impact on informal caregivers. While the intent, benefits and eligibility criteria varied considerably across programs, the conditions of any individual program are a consideration in applying the framework. Program eligibility criteria determine whether informal caregivers, or their care receivers, are eligible for benefits under a particular program. If individuals qualify, then the economic impact of the policy instrument can be assessed by further applying the policy analysis framework.

Figure 1. Policy Analysis Framework



Moderating Characteristics

The second component of the policy analysis framework is a set of caregiver, care receiver and regional characteristics that mediate the effect of any given policy on the economic outcomes affecting informal caregivers. The original set of salient characteristics, which were identified in the process of developing the caregiver profiles, describing the regions and determining the program eligibility criteria, was refined as a result of our policy impact analysis. Some caregiver characteristics mediated the impact of policies on the economic well-being of caregivers. Some regional characteristics were economically influential. And, while care receiver characteristics predominated among eligibility criteria, only one care receiver characteristic was found to affect the economic impact of policies on informal caregivers. In summary, the key moderating factors are presence of young children, labour force status, geographic proximity, care receiver income and regional economy. While the inclusion of these mediating characteristics ensures that the policy analysis framework is sensitive to the heterogeneity of informal caregivers and regional diversity within Canada, all mediating factors are not relevant for all programs, policy instruments or policy domains.

Gender of the Caregiver

The third component of the policy analysis framework is gender of the caregiver. While the relevance of the five mediating characteristics listed previously varies by program, the gender of the caregiver is a constant filter in the framework because of the ubiquitous nature of gender differences in the social context in which we live, specifically in elder care. Further, these social realities have an economic impact. Thus, the differential effects of policies, programs and legislation on women and men caregivers are unmasked when gender is explicitly considered in policy analysis (Status of Women Canada 1996).

It is important to note that while the women in our caregiver profiles were married, employed/retired and had average annual incomes, the economic impact of policies may be greater for women whose characteristics differ. For example, lone-parent families headed by women, Aboriginal peoples, members of visible minorities and individuals with disabilities tend to have less income than their peers (Ross et al. 2000).

Types of Economic Costs

The fourth and final component of the policy analysis framework is the potential economic impact of a given program/policy instrument on informal caregivers. As noted in Chapter 2, stakeholder groups experience different economic and non-economic costs (Fast et al. 1999b). Five types of economic costs that informal caregivers may experience were identified. In applying the framework, we found that these five types were, in fact, the key types of economic costs informal caregivers may experience because of a particular policy instrument or program: lost current and future income, lost employment benefits, out-of-pocket expenses and unpaid labour.

In conclusion, the relationship between a given program and types of economic costs incurred are moderated by caregiver and care receiver characteristics, the gender of the caregiver and the interactions among these caregiver, care receiver and regional characteristics. Thus, the case study methodology must be used when applying the policy analysis framework to evaluate the economic impact of policies. Both existing and new policies and programs need to be analyzed through the use of typical case studies, like the caregiver profiles, to determine the impact of a given policy on the types of economic costs incurred by informal caregivers. In the next chapter, we present the conclusions and recommendations based on our case study analyses of the economic impact of health, income security and labour policies on different informal caregivers living in different regions of Canada.

4. CONCLUSIONS AND POLICY RECOMMENDATIONS

Our foregoing policy analysis allows us to draw a number of conclusions about the way in which policies likely affect the economic consequences experienced by informal caregivers. We begin with an evaluation of which types of economic consequences are most tractable to policies, programs and services. We then evaluate the characteristics of policies, programs and services that influence the impact they will have on caregiver costs. We conclude by making recommendations for policy reform.

Common Economic Consequences

Our analysis suggests that existing policies, programs and services probably have the greatest potential to affect caregivers' out-of-pocket costs. These costs frequently arise from the senior's inability to meet her/his own needs due to inadequate income, user fees and low ceilings on means tests. When low-income care receivers cannot afford to purchase the medications, assistive devices and help they require, these costs frequently are absorbed by caregivers (Glendinning 1992). User fees and low ceilings on means tests make services less affordable to more low-income seniors with the result that they are more likely to require the assistance of family and friends.

Employment-related costs probably have the greatest potential to affect caregivers' costs. Tardiness, absenteeism, working fewer hours and exiting the labour force to fulfill caregiving responsibilities commonly are reported by caregivers. These responses result in lost current and future income, and employer-provided benefits. Ironically, they are also the least likely to be addressed by existing policies, programs and services. Indeed, only family responsibility leave does so directly, and it is mandated in only one of the three jurisdictions we examined.

The extent to which direct labour costs are affected by policies, programs and services is unclear. Available evidence suggests that the provision of formal services does not induce informal caregivers to reduce their caring labour. Rather, it is more likely to increase it by enabling them to continue to provide care longer. What is not known is how informal caregivers respond to *decreases* in formal services, as a result of recent reform in the health and continuing care policy sectors. It may well be that families and friends will pick up the slack, thereby increasing their direct labour costs.

Characteristics of Policies, Programs and Services

Our analysis highlighted several characteristics of policies, programs and services that influence the economic consequences caregivers experience. These include:

- the existence of a policy, program or service;
- the targeted beneficiary;
- conflicting policy objectives; and
- eligibility criteria.

Obviously, the simple presence or absence of programs and services that offset the costs of seniors' health- and disability-related expenditures has the potential to affect the economic status of caregivers. For example, British Columbian caregivers face different costs than those in the other provinces examined because family responsibility leave is mandated in British Columbia. Caregivers in rural Cape Breton face higher costs than caregivers in the other provinces because they lack access to adult day programs, consultation services and equipment plans that are available to their counterparts in British Columbia and Ontario. As was noted above, income adequacy determines the extent to which seniors are able to meet their own care needs. Poverty rates have declined markedly for seniors over the last few decades, but rates remain relatively high, especially among unattached women. One particular feature of the CPP/QPP system seems destined to perpetuate this problem—lack of a drop-out provision for adults who are ill, frail or have a disability.

Even where programs and services exist, certain of their characteristics can affect the magnitude of a caregiver's costs. Perhaps most important, of the policies, programs and services reviewed, only the caregiver tax credit actually targets the caregiver. This continues to be true despite abundant rhetoric from policy makers about the important contributions of the informal care sector, and the need to support them in their work. Numerous provisions have the potential to benefit the caregiver indirectly, either by increasing the senior's ability to meet her/his own functional and financial needs, or by passing on tax savings from the senior to the caregiver. However, it is difficult to estimate the extent to which these actually benefit caregivers because of their indirect nature and complexity. For example, the tax and transfer system is so complicated that few have a hope of obtaining the maximum benefit to which they are entitled.

It also was observed that conflicting objectives across policy sectors are common. For example, prohibitions against gender discrimination in pay and employment practices, and family-friendly workplace policies, facilitate women's access to the labour market (and, in turn, their own current and future economic security). Yet policy reform in the health and continuing care sectors that increases reliance on informal caregivers to meet seniors' needs likely obstructs achievement of the objectives of gender equity policy. Similarly, reform in the income security sector, which requires employable social assistance recipients to seek training or employment (regardless of rate of pay), will further restrict informal caregivers' ability to provide needed care without facing financial ruin.

Another common theme that emerged was a marked incongruence between the characteristics that strongly predict economic consequences for caregivers and program eligibility criteria. For example, many programs and services employ eligibility criteria based on relationship, typically restricting eligibility to close kin. As a result, the 19 percent of informal caregivers who are non-kin almost always are excluded; a further 19 percent of distant kin caregivers (siblings, nieces, nephews, aunts, uncles, grandparents, etc.) are sometimes excluded. Yet relationship was not found to be a strong predictor of the economic consequences of caregiving (Keating et al. 1999).

Many programs also employ proximity as an eligibility criterion, restricting eligibility to caregivers and care receivers who co-reside. While research shows that out-of-pocket costs can be greater for caregivers who have a frail senior living with them (Glendinning 1992), it

also shows significant economic consequences for those living at a moderate distance (Keating et al. 1999). In addition to the added time and out-of-pocket costs associated with commuting, these caregivers report more employment consequences. More to the point, perhaps, few caregivers actually live with those for whom they care.

Perhaps the most common eligibility criterion is the care receiver's income which, as was observed above, determines the senior's ability to meet her/his own care needs. Indeed, even the one policy instrument that targets caregivers—the caregiver tax credit—includes care receiver income among its eligibility criteria. As noted above, these income ceilings tend to be very low, making the majority of caregivers ineligible for benefits.

In contrast, characteristics such as gender and the competing demands of child care and employment responsibilities, which *have* been found to be strong predictors of economic consequences (Keating et al. 1999), typically are *not* taken into account in determining need and eligibility for most programs and services. Women consistently experience greater costs. They constitute the majority of elder-care providers and spend the most time providing care. They also are more likely than men to have multiple family care responsibilities. Most are employed, but they are more likely to work part time and earn less than their male counterparts. They also are more likely than men to forfeit employment opportunities in order to fulfill their care responsibilities. Unattached senior women—a growing portion of the senior population—are at high risk of poverty and are less likely to be able to meet their financial and functional needs themselves.

Nor are allowances made for important characteristics of the caregiver–care receiver dyad, such as quality of the relationship. Our consultants pointed out that there are families whose histories make the expectation of providing informal care to parents improbable. In some cases, such as where there is a history of abuse, mandating family care may even be undesirable. As one consultant stated: "Our agency has always been advocating for the support and flexibility in the system that will allow for the nuances that happen to people's lives because we are all human and we all come with different stories and different histories and different baggage that we carry along with it."

In sum, caregivers who are least well-served by existing policy instruments are women who are employed, who have concurrent child-care responsibilities and who live at a moderate distance from their care receiver. Non-kin are especially poorly served. Poverty of the care receiver is a double-edged sword: poor seniors, and those caring for them, are more likely to be eligible for benefits, but they also are less able to cover the costs of caring for themselves.

Two final cautions must be issued about the comprehensiveness of our analysis. Only the economic costs experienced by informal caregivers have been examined here. As has been observed elsewhere (Fast et al. 1999b), other stakeholders also experience costs arising from the provision of informal care. Caregivers' costs are experienced not just by the caregiver, but also by the spouse and children. Employees with family care responsibilities are often less productive which affects employers' costs. Public sector costs arise when care responsibilities compromise caregivers' financial and physical well-being.

In addition, not all caregivers are represented in the case studies used in our analysis. The experiences of lone-parent caregivers, unemployed adult child caregivers, distant kin and friends may be somewhat different than those of the caregivers profiled. Nor were all regions of the country or all policy sectors accounted for in our policy scan. Thus, there may be policy instruments that were not examined. However, we are confident that the framework provided will permit assessment of the situations of specific caregivers living in specific regions.

Recommendations for Policy Reform

Based on the preceding discussion, we have made a number of recommendations for policy reform. These recommendations are presented in Table 4 along with the key policy instruments that need attention, based on our analysis of the impact of policies on the economic well-being of Canadian informal caregivers.

Table 4. Recommendations for Policy Reform

Policy Recommendations	Key Policy Instruments Needing Reform
Increase income ceilings on means tests to current poverty lines[8] as a minimum. Current income limits are well below the poverty level.	• Federal and provincial guaranteed annual income supplement programs • Caregiver tax credit • Equivalent-to-spouse tax credit • Amount for infirm dependents over 18 years of age tax credit • Medical expenses tax credit
Reduce or waive user fees for low-income individuals. User fees reduce access to services, especially for low-income individuals, and charges are likely to be absorbed by informal caregivers.	• Provincial home care and other community home support service programs • Adult day programs • Provincial drug plans • Provincial home oxygen programs
Directly subsidize equipment to support community living. Direct subsidies are more economically efficient than tax credits/deductions and more likely to provide meaningful benefits to a broader range of care receivers and their caregivers.	• Provincial assistive device programs • Medical expenses tax credit
Mandate family responsibility leaves and extend eligibility to those with elder-care responsibilities.	• *Canada Labour Code* • Provincial employment standards
Acknowledge the economic value of informal caregivers' unpaid labour. Let economic value guide policy reforms, for example, provide an elder-care drop-out provision in the CPP/QPP or allow informal caregivers who leave the paid labour force to provide elder care with the ability to contribute to CPP/QPP. Welfare-to-work policies might be changed to exempt informal caregivers from seeking employment, particularly in regions with high unemployment rates.	• Canada Pension Plan • Provincial social assistance programs
Develop national standards for the provision of continuing care. The tremendous variability in continuing care programs across regions leads to inequities in the experiences of, and costs to, seniors and their informal caregivers. Those living in poor and isolated regions are often disadvantaged.	• *Canada Health Act* or new legislation

Table 4 (cont'd)

Policy Recommendations	Key Policy Instruments Needing Reform
Base eligibility for programs on the caregiver as well as care receiver characteristics. Eligibility should consider characteristics, such as gender, employment status, presence of young children, geographic proximity, as well as income of the care receiver.	• Provincial home care programs • Caregiver tax credit • Medical expenses tax credit • Family responsibility leave
Simplify the tax and transfer system so frail seniors and their informal caregivers may benefit from programs to which they are entitled.	• Caregiver tax credit • Equivalent-to-spouse tax credit • Amount for infirm dependants over 18 years of age tax credit • Disability tax credit • Medical expenses tax credit
Increase the level of benefit provided by income tax credits to give *meaningful* relief to frail seniors and their informal caregivers.	• Caregiver tax credit • Disability tax credit • Medical expenses tax credit
Use the policy analysis framework to evaluate the economic impact of policies on informal caregivers across all levels of government. Base priorities for policy reform on this scan, with special attention to gender and regional disparities.	• Federal/provincial/territorial programs in domains that influence caregiver economic impact

APPENDIX A: DEPENDENT VARIABLES USED IN CHAID ANALYSES

Time spent providing elder care refers to the total hours per week spent providing assistance across all the specified elder care tasks (meal preparation, housework, home maintenance/repairs, shopping, bills/banking, transportation and personal care).

Job adjustments refers to the extent to which employed respondents had made changes to their employment in order to meet caregiving demands such as changing hours of work, coming to work late or leaving work early, missing a day or more of work, or having job performance affected.

Postponements refers to opportunities that were delayed or foregone in order to provide care such as postponing educational plans, declining a job transfer or promotion or turning down a job offer.

Socio-economic consequences refers to whether the caregiver changed social activities, changed holiday plans, changed sleep patterns or had extra expenses because of caregiving responsibilities.

Burden refers to the psychological and emotional hardships arising from caregiving. This includes not having enough time for family and work, or for oneself, feeling angry when around the care receiver, wishing someone would take over caregiving, having one's health affected, and having an overall feeling of burden.

APPENDIX B: STAKEHOLDERS

Phyllis Bentley, President
One Voice — The Canadian Seniors Network
Penticton, British Columbia

Kathy Darte, Planning and Negotiations Co-ordinator
Health Care Division
Veterans Affairs Canada
Charlottetown, Prince Edward Island

Nadia Diakun-Thibault, President
Caregivers' Association of Ontario
Ottawa, Ontario

Lorna Hillman, Executive Director
Family Caregivers Network Society
Victoria, British Columbia

Claire Nyiti, Director of Home Care
Eastern Region of Nova Scotia
Sydney, Nova Scotia

Barbara Snelgrove, Co-ordinator Support Services/Education
Alzheimer Society of Canada
Toronto, Ontario

APPENDIX C: ANNUAL INCOME LEVEL IN 1996 OF INDIVIDUALS AND FAMILIES, BY AGE AND REGION

Description	Capital Region (BC) $	Niagara Region (ON) $	Rural Cape Breton Region (NS) $
Age 30-44 years			
Women's average personal income	24,139	20,877	15,750
Men's average personal income	32,794	35,005	27,258
Average family income	56,933	55,882	42,087
Ages 45-60 years			
Women's average personal income	26,450	20,844	16,046
Men's average personal income	43,074	41,402	30,095
Average family income	69,524	62,246	45,801
Ages over 75 years			
Women's average personal income	20,879	16,488	13,291
Men's average personal income	34,143	26,914	18,808
Average family income	55,022	43,402	32,851

APPENDIX D: REVIEWED POLICY DOCUMENTS

Government of Canada Policy Instruments

Bill C-25: An Act to amend the Income Tax Act, the Excise Tax Act, and the Budget Implementation Act. First reading. 36th Parliament, 2nd Session. 1999-2000. <http://www.parl.gc.ca/36/2/parlbus/chambus/house/bills/government/C-25/C-25_1/C-25_cover-E.html>.

Canada Customs and Revenue Agency. 1999. *General income tax and benefit guide - 1999*. <http://www.ccra-adrc.gc.ca/E/pub/tg/5000geq-48.html>.

Department of Finance. 1998. *The federal budget: February 24, 1998*. North York, ON: CCH Canadian.

Department of Justice Canada. 1997a. *Canada pension plan: Chapter C-8*. <http://canada.justic.gc.ca/STABLE/EN/Laws/Chap/c/c-8.html>.

———. 1997b. *Old age security act: Chapter O-9*. <http://canada.justice.gc.ca/STABLE/EN/Laws/Chap/0/0-9.html>.

———. 1998. *Canada health act: Chapter C-6*. <http://canada.justice.gc.ca/FTP/EN/Laws/Chap/C/C-6.txt>.

Health Canada. 1998. *Canada health act: Overview.* August. <http://hwcweb.hwc.ca/medicare/chaover.htm>.

———.1999. *Fact sheet: The federal role in health*. February. <http://hwcweb.hwc.ca/budget/english/factsht7.htm>.

Health Canada, Division of Aging and Seniors. 1998. *1998 Seniors guide to federal programs and services.* <http://www.hc-sc.gc.ca/seniors-aines>.

Human Resources Development Canada. 1996. *Division of legislative powers.* <http://labour-travail.hrdc-drhc.gc.ca/policy/leg/e/stand-el.html>.

———. 1997a. *Employment standards legislation in Canada*. <http://labour-travail.hrdc-drhc.gc.ca/policy/leg/e/stand-el.html>.

———. 1997b. *Overview: Income security programs: Old age security, Canada pension plan*. Report # ISPB-100-07-97E.

———. 1998a. *Canada labour code* (R. S., c. L-1, s.1). <http://labour-travail.hrdc-drhc.gc.ca/doc/lab-trav/eng/clc-cct/toc.html>.

———. 1998b. *Employment standards legislation in Canada*. <http://labour-travail.hrdc-drhc.gc.ca/policy/leg/e/stan10-el.html>.

———. 1998c. *Canada pension plan: Legislative changes*. July. <http://www.hrdc-drhc.gc.ca/isp/cpp/cpp/cqa.shtml>.

———. 1999. *Who is covered by the standards of the Canada labour code*? <http://info.load-otea.hrdc-drhc.gc.ca/~lsweb/lscoveen.htm>.

———. 2000a. *The repayment of Old Age Security Pension Benefits*. January 31. <http://www.hrdc-drhc.gc.ca/isp/oas/oasrepay_e.shtml>.

———. 2000b. *Retirement pension*. February 7. <http://www.hrdc-drhc.gc.ca/isp/cpp/retire_e.shtml>.

———. 2000c. *Survivor benefits*. March 28. <http://www.hrdc-drhc.gc.ca/isp/cpp/surviv_e.shtml>.

———. 2000d. *General information about the Canada pension plan*. May 15. <http://www.hrdc-drhc.gc.ca/isp/cpp/genera_e.shtml>.

———. 2000e. *The Widowed Spouse's Allowance*. May 26. <http://www.hrdc-drhc.gc.ca/isp/oas/ispb124b_e.shtml>.

———. 2000f. *The repayment of old age security pension benefits for residents of Canada*. July 21. <http://www.hrdc-drhc.gc.ca/isp/oas/oasrepay_e.shtml>.

———. 2000g. *Old age security pension*. July 21. <http://www.hrdc-drhc.gc.ca/isp/oas/ispb185.shtml>.

———. 2000h. *Income security programs. Old age security, guaranteed income supplement, spouse's allowance. Table of rates in effect July-September 2000*.

Revenue Canada. 1998a. *Medical expense and disability interpretation bulletin*. IT-519R2. <http://www.rc.gc.ca/E/pub/tp/519r2ed/519r2ed.html>.

———. 1998b. *Information concerning people with disabilities*. RC4064(E). <http://www.rc.gc.ca/E/pub/tg/rc4064ed/rc4064ed/html>.

Sims, A.C.L., R. Blouin and P. Knopf. 1998. *Canada labour code. Part 1 Review: Seeking a balance*. <http://labour-travail.hrdc-drhc.gc.ca/labour/labstand/toc.html>.

Statistics Canada. 1998. *Statistical profile of Canadian communities.* <http://ww2.statcan.ca/english/profil/>.

Province of British Columbia and Capital Region Policy Instruments

British Columbia. 1999. *Continuing care act*. RSBC 1996, Chapter 70. In *1996 Revised statutes of British Columbia*. <http://www.qp.bc.ca/bcstats/96070_01.htm>.

British Columbia, Ministry of Health. 1998. *Review of continuing care services: Consultation document*.

British Columbia, Ministry of Health and Ministry Responsible for Seniors. 1998. *Pharmacare*. <http://www.hlth.gov.bc.ca/pharme/plan.html>.

———. 1999. *Medical services plan*. July. <http://www.hlth.gov.bc.ca/msp/index.html>.

British Columbia, Ministry of Human Resources. 1999. *Income support programs*. February. <http://www.sdes.gov.bc.ca/programs/ispprog.htm#1c>.

British Columbia, Ministry of Labour. 1996a. *Employment standards act*. <http://www.labour.gov.bc.ca/esb/facshts/exclusio/act_toc.htm>.

———. 1996b. *Employment standards act and regulations: Interpretation guidelines manual*. <http://www.labour.gov.bc.ca/esb/igm2/igmp06.htm>.

———. 1996c. *Employment standards regulation*. <http://www.labour.gov.bc.ca/esb/facshts/exclusio/reg_toc.htm>.

———. 1996d. *Fact sheet: Leaves and jury duty*. <http://www.labour.gov.bc.ca/esb/facshts/leave.htm

———. 1999. *Government revamps regulations to aid high-tech growth: New standards improve workplace flexibility*. News release AE06-99. <http://www.labour.gov.bc.ca/hightech/02-01-99.htm>.

British Columbia, Ministry of Social Development and Economic Security. 1999a. *British Columbia benefits manual: Section 3.2 - Legislation - BC benefits (income assistance) act*. <http://www.sdes.gov.bc.ca/publicat/vol1/3-2.htm>; *Section 3.3 - Legislation - Income Assistance Regulations.* April. <http://www.sdes.gov.bc.ca/publicat/vol1/3-3.htm#36>.

———. 1999b. *Applying for BC benefits*. November 10. <http://www.sdes.gov.bc.ca/publicat/fasttrak/b.htm>.

———. 2000. *BC benefits income assistance and disability benefits rates*. July 19. <http://www.sdes.gov.bc.ca/publicat/welf2wk.htm#regular>.

Capital Health Region. 1999. *Directory of community services.* February. <http://www.crd.bc.ca/disrv/html/indexes>.

Dale v. *Gregson*, BCEST D496/97. British Columbia Employment Standards Tribunal, 1997.

Greater Victoria Hospital Society. 1996. "Home oxygen therapy referral for the capital region of British Columbia." Brochure. Victoria, B.C. October.

Maatbuis, D. and P. Miller. 2000. "Changes in access to long term care services." *Family Caregivers Network Society.* Spring, 13.

Office for Seniors. 1991. *Information for seniors.* Third edition. Victoria: Ministry of Health and Ministry Responsible for Seniors.

———. 1999a. *Information for seniors guide: Finances*. February. < http://www.hlth.gov.bc.ca/seniors/docs/info/finances.html>.

———. 1999b. *Information for seniors guide: Health services.* April. <http://www.hlth.gov.bc.ca/seniors/docs/info/health.html#acute&continuing>.

Seniors Serving Seniors. 1998/99. *Seniors' services directory: A community resource handbook for the Capital Region*. Victoria.

Steering Committee of the Review of Continuing Care in British Columbia. 1999. Community for life: Review of continuing care services in British Columbia. Victoria: BC Ministry of Health.

Province of Ontario and Region of Niagara Policy Instruments

Ontario, Ministry of Community and Social Services. 1998. *Ontario government business plans: 1998-1999. Ministry of community and social services*. <http://gov.on.ca/MBS/english/press/plans98/css.html#2>.

———. 1999. *Ontario works: Information for participants*. <http://www.gov.on.ca/CSS/page/brochure/owia.html#What is>.

Ontario, Ministry of Finance. 1999. "Information Bulletin: Guaranteed Annual Income System (GAINS-1)." Brochure. August.

———. 2000. "GAINS: The guaranteed annual income system for Ontario senior citizens. Benefits for the period April to June 2000." Oshawa, ON. March.

Ontario, Ministry of Health and Long-Term Care. 1996. *Community care access centres: Board orientation*. Toronto, June.

———. 1998. *Long-term care*. Toronto, December.

———. 1999a. "Community care access centres." Brochure. Toronto, February.

———. 1999b. *1999/2000 Planning, funding and accountability policies and procedures manual for long-term care community services.* Section 4, Sixth edition. Toronto.

———. 1999c. *Programs and services: Assistive devices program*. <http://www.gov.on.ca/health/english/program/adp/adp_mn.html>.

———. 1999d. *Programs and services: Drug programs*. <http://www.gov.on.ca/health/english/program/drugs/drugs_mn.html>.

Ontario, Ministry of Labour. 1999. *Employment standards*. <http://www.gov.on.ca/LAB/es/ese/htm#esg>.

Ontario Health Insurance Plan. 1999. "Frequently asked questions." <http://www.gov.on.ca/health/english/program/ship/ohopfaq_dt.html#Q12>.

Regional Municipality of Niagara. 2000. *Community services department: Profile of services*. June 27. <http://www.regional.niagara.on.ca/departments/soc-seniors/index.html>.

Statutes of Ontario. 1994. *Long-term care act, 1994*. <http://209.195.107.57/cgi-bin/om_isapi.dll?clientID=8320&advquery=>.

Province of Nova Scotia and Region of Cape Breton Policy Instruments

Home Care Nova Scotia. 1994. *A plan for implementation*. Halifax, NS, October.

———. 1997. *Policy and procedures manual.* Second edition. Halifax, May.

———. 1999. "Home oxygen service: Procedures and guidelines." Brochure. Halifax, February.

The Minister's Action Committee on Health System Reform. 1994. *Nova Scotia's blueprint for health system reform*. Halifax: Nova Scotia Department of Health, April.

Nova Scotia, Department of Community Services. 1999. *Income and employment support services*. January. <http://www.gov.ns.ca/coms/i&ess.htm#CommunitySupportforAdults>.

———. 2000a. *New income assistance system for Nova Scotia*. June 12. <http://www.gov.ns.ca/news/details.asp?id=20000612004>.

———. 2000b. *Social assistance redesign project*. <http://www.gov.ns.ca/coms/redesign.htm>.

Nova Scotia, Department of Health. 1996. *Department of health*. <http://www.gov.ns.ca/govt/foi/health.htm#top>.

———. 1999a. *Health minister accepts recommendations of seniors' pharmacare working group*. February. <http://www.gov.ns.ca/health/media/1999/feb8.htm>.

———. 1999b. *The minister's task force on regionalized health care in Nova Scotia: Final report and recommendations*. <http://www.gov.ns.ca/health/taskforce/default.htm>.

Nova Scotia, Department of Labour. 1998a. *About the department*. August. <http://www.gov.ns.ca/labr/dept.htm>.

———. 1998b. *Guide to the labour standards code of Nova Scotia*. <http://www.gov.ns.ca/labr/lstcode/index.htm#Leaves>.

Nova Scotia, Office of the Legislative Counsel. 1998a. *Social assistance act* (R. S., c. 432, s.1). September. <http://www.gov.ns.ca/legi/legc/statutes/socialas.htm>.

———. 1998b. *Senior citizens' financial aid act.* (R. S., c. 419, s.1). <http://www.gov.ns.ca/legi/legc/statutes/sencitfa.htm>.

Nova Scotia Regulations. 1999a. *General labour standards code regulations*. January. <http://www.gov.ns.ca/just/regulations/regs/lsc15496.htm>.

———. 1999b. *Municipal assistance regulations*. <http://www.gov.ns.ca/just/regulations/regs/samunass.htm>.

———. 1999c. *Seniors' pharmacare program regulations*. <http://www.gov.ns.ca/just/regulations/regs/hsisenor/htm>.

Nova Scotia Senior Citizens Secretariat. 1998. "Home care and support services." *Programs for Seniors.* 9: 52-66.

Nova Scotia Seniors' Pharmacare Program. 1999. "Information sheet." Brochure. Halifax, February.

APPENDIX E: PROGRAM ELIGIBILITY CHARACTERISTICS BY POLICY DOMAIN AND TYPE OF POLICY INSTRUMENT

	Caregiver Characteristics							Dyad Characteristics			Care Receiver Characteristics							
	Children <15	Labour Force Status	Marital Status of CG	Availability of CG	Income	Assets	Family Composition	Being a Primary Caregiver	Proximity	Relationship to CR	Health Status	Income	Assets	Age	Marital Status	Family Size	Length/ Continuity of Residence	Employment History
Health																		
Home care programs				X							X	X		X		X	X	
Adult day programs									X		X			X				
Consultation services											X			X			X	
Drug plans												X		X	X			
Home oxygen programs											X	X				X		
Equipment plans											X							
Physician and hospital services											X	X		X		X	X	
Income Security																		
Social assistance programs					X	X	X											
Old Age Security														X				
Canada Pension Plan														X				X
Guaranteed Income Supplement												X			X			
Spouse's Allowance												X		X	X			
Provincial income supplement programs for seniors												X	X	X	X		X	
Attendant care expense tax deduction										X								
Caregiver tax credit									X	X		X		X				
Equivalent-to-spouse amount			X						X	X	X	X						
Amount for infirm dependants age 18+									X	X	X	X		X				
Disability tax credit										X	X	X						
Medical expense tax credit										X		X						
Provincial tax credits												X		X	X			

Appendix E (cont'd)

	Caregiver Characteristics							**Dyad Characteristics**			**Care Receiver Characteristics**							
	Children <15	Labour Force Status	Marital Status of CG	Availability of CG	Income	Assets	Family Composition	Being a Primary Caregiver	Proximity	Relationship to CR	Health Status	Income	Assets	Age	Marital Status	Family Size	Length/ Continuity of Residence	Employment History
Labour																		
Family responsibility leave		X								X								
frequency	0	1	1	1				0	4	7	9	13	1	12	5	3	4	1

Notes:
Characteristics that are predictors of high caregiver consequences or involvement are in *italics*.
In contrast, program eligibility is largely based on care receiver characteristics, although some programs depend on caregiver–care receiver dyad characteristics.

APPENDIX F: POLICY IMPACT ANALYSIS BY CAREGIVER PROFILE

A policy impact analysis was completed for each of six caregiver profiles across each region. The resulting information is the most generous interpretation of what the impact of policies may be on the economic costs to these caregivers.

Profile 1: Rebecca, Adult Child Caregiver, Married with Two Young Children, Employed Full Time

Program	Capital Region (BC)	Niagara Region (ON)	Cape Breton Region (NS)
	Caregiver's personal income $24,139	Caregiver's personal income $20,877	Caregiver's personal income $15,750
	Caregiver's family income $56,933	Caregiver's family income $55,882	Caregiver's family income $42,087
	Care receiver's family income $55,022	Care receiver's family income $43,402	Care receiver's family income $32,851
Labour			
Family responsibility leave	↓ Current income ↑ Future income ↑ Employment benefits ↓ Out-of-pocket costs ↑ Unpaid labour	N/A	N/A
Income Security			
Provincial social assistance programs	CG is not eligible	CG is not eligible	CG is not eligible
Old Age Security	↓ Out-of-pocket costs	↓ Out-of-pocket costs	↓ Out-of-pocket costs
Canada Pension Plan	↓ Out-of-pocket costs	↓ Out-of-pocket costs	↓ Out-of-pocket costs
Guaranteed Annual Income Supplement	CR is not eligible	CR is not eligible	CR is not eligible
Spouse's Allowance	CR is not eligible	CR is not eligible	CR is not eligible
Provincial income supplement programs	CR is not eligible	CR is not eligible	CR is not eligible
Attendant care expenses tax deduction	↓ Out-of-pocket costs	↓ Out-of-pocket costs	↓ Out-of-pocket costs
Caregiver tax credit	CG is not eligible	CG is not eligible	CG is not eligible
Equivalent-to-spouse tax credit	CG is not eligible	CG is not eligible	CG is not eligible
Tax credit for infirm dependants > 18 years	CG is not eligible	CG is not eligible	CG is not eligible
Disability tax credit	↓ Out-of-pocket costs	↓ Out-of-pocket costs	↓ Out-of-pocket costs
Medical expenses tax credit	CG is not eligible	CG is not eligible	CG is not eligible
British Columbia surtax reduction	CG is not eligible	N/A	N/A
NS low income tax deduction	N/A	N/A	CG is not eligible

Profile 1: Rebecca (cont'd)

Program	Capital Region (BC)	Niagara Region (ON)	Cape Breton Region (NS)
Health			
Home care	↑ Current income ↑ Out-of-pocket costs ↑ Unpaid labour for light housekeeping	↑ Current income ↑ Out-of-pocket costs	↑ Current income ↑ Out-of-pocket costs ↑Unpaid labour for shopping, banking and other errands
Adult day programs	↑ Out-of-pocket costs	↑ Out-of-pocket costs	N/A
Consultation services—impacts will be greater in ON than BC given broader range of services available	↓ Current income ↑ Unpaid labour	↓ Current income ↑ Unpaid labour	N/A
Drug plans	↓ Out-of-pocket costs	↓ Out-of-pocket costs	↓ Out-of-pocket costs
Home oxygen programs	↓ Out-of-pocket costs	↓ Out-of-pocket costs	↓ Out-of-pocket costs
Equipment plans	N/A	↓ Out-of-pocket costs	N/A
Physician and hospital services—impact varies by comprehensiveness of basic health care benefits and premiums	↑ Out-of-pocket costs for basic health care premium ↓ Out-of-pocket costs for more comprehensive health care	No premiums charged ↓ Out-of-pocket costs, but less comprehensive health care	No premiums charged but least comprehensive health care

Profile 2: Rob, Adult Child Caregiver, Married With Two Young Children, And Employed Full Time

Program	Capital Region (BC)	Niagara Region (ON)	Cape Breton Region (NS)
	Caregiver's personal income $32,794	Caregiver's personal income $35,005	Caregiver's personal income $27,258
	Caregiver's family income $56,933	Caregiver's family income $55,882	Caregiver's family income $42,087
	Care receiver's family income $55,022	Care receiver's family income $43,402	Care receiver's family income $32,851
Labour			
Family responsibility leave	Unlikely to impact current income, future income and employment benefits	N/A	N/A
Income Security			
Provincial social assistance programs	CG is not eligible	CG is not eligible	CG is not eligible
Old Age Security	↓ Out-of-pocket costs	↓ Out-of-pocket costs	↓ Out-of-pocket costs
Canada Pension Plan	↓ Out-of-pocket costs	↓ Out-of-pocket costs	↓ Out-of-pocket costs
Guaranteed Annual Income Supplement	CR is not eligible	CR is not eligible	CR is not eligible
Spouse's Allowance	CR is not eligible	CR is not eligible	CR is not eligible
Provincial income supplement programs	CR is not eligible	CR is not eligible	CR is not eligible
Attendant care expenses tax deduction	↓ Out-of-pocket costs	↓ Out-of-pocket costs	↓ Out-of-pocket costs
Caregiver tax credit	CG is not eligible	CG is not eligible	CG is not eligible
Equivalent-to-spouse tax credit	CG is not eligible	CG is not eligible	CG is not eligible
Tax credit for infirm dependants > 18 years	CG is not eligible	CG is not eligible	CG is not eligible
Disability tax credit	↓ Out-of-pocket costs	↓ Out-of-pocket costs	↓ Out-of-pocket costs
Medical expenses tax credit	CG is not eligible	CG is not eligible	CG is not eligible
BC surtax reduction	CG is not eligible	N/A	N/A
NS low income tax deduction	N/A	N/A	CG is not eligible

Profile 2: Rob (cont'd)

Program	Capital Region (BC)	Niagara Region (ON)	Cape Breton Region (NS)
Health			
Home care	↑ Out-of-pocket costs	↑ Out-of-pocket costs	↑ Out-of-pocket costs ↑ Unpaid labour for shopping, banking and other errands
Adult day programs	↑ Out-of-pocket costs	↑ Out-of-pocket costs	N/A
Consultation services—impacts will be greater in ON than BC given broader range of services available	↓ Current income ↑ Unpaid labour	↓ Current income ↑ Unpaid labour	N/A
Drug plans	↓ Out-of-pocket costs	↓ Out-of-pocket costs	↓ Out-of-pocket costs
Home oxygen programs	↓ Out-of-pocket costs	↓ Out-of-pocket costs	↓ Out-of-pocket costs
Equipment plans	N/A	↓ Out-of-pocket costs	N/A
Physician and hospital services—impact varies by comprehensiveness of basic health care benefits and premiums	↑ Out-of-pocket costs for basic health care premium ↓ Out-of-pocket costs for more comprehensive health care	No premiums charged ↓ Out-of-pocket costs, but less comprehensive health care	No premiums charged but least comprehensive health care

Profile 3: Joan, Adult Child Caregiver, Married with One Adult Child at Home, Employed Full Time and Primary Caregiver

Program	Capital Region (BC)	Niagara Region (ON)	Cape Breton Region (NS)
	Caregiver's personal income $26,450	Caregiver's personal income $20,844	Caregiver's personal income $16,046
	Caregiver's family income $69,524	Caregiver's family income $62,246	Caregiver's family income $45,801
	Care receiver's income $20,879	Care receiver's income $16,488	Care receiver's income $13,291
Labour			
Family responsibility leave	↓ Current income ↑ Future income ↑ Employment benefits ↓ Out-of-pocket costs ↑ Unpaid labour	N/A	N/A
Income Security			
Provincial social assistance programs	CG is not eligible	CG is not eligible	CG is not eligible
Old Age Security	↓ Out-of-pocket costs	↓ Out-of-pocket costs	↓ Out-of-pocket costs
Canada Pension Plan	↓ Out-of-pocket costs	↓ Out-of-pocket costs	↓ Out-of-pocket costs
Guaranteed Annual Income Supplement	CR is not eligible	CR is eligible	CR is eligible
Spouse's Allowance	CR is not eligible	CR is not eligible	CR is not eligible
Provincial Income Supplement Programs	CR is not eligible	CR is not eligible	CR is eligible
Attendant care expenses tax deduction	↓ Out-of-pocket costs	↓ Out-of-pocket costs	↓ Out-of-pocket costs
Caregiver tax credit	CG is not eligible	CG is not eligible	CG is not eligible
Equivalent-to-spouse tax credit	CG is not eligible	CG is not eligible	CG is not eligible
Tax credit for infirm dependants > 18 years	CG is not eligible	CG is not eligible	CG is not eligible
Disability tax credit	↓ Out-of-pocket costs	↓ Out-of-pocket costs	↓ Out-of-pocket costs
Medical expenses tax credit	CG is not eligible	CG is not eligible	CG is not eligible
BC surtax reduction	CG is not eligible	N/A	N/A
NS low income tax reduction	N/A	N/A	↓ Out-of-pocket costs

Profile 3: Joan (cont'd)

Program	Capital Region (BC)	Niagara Region (ON)	Cape Breton Region (NS)
Health			
Home Care	↑ Current income ↑ Out-of-pocket costs ↑ Unpaid labour for light housekeeping	↑ Current income ↑ Out-of-pocket costs	↑ Current income No out-of-pocket costs ↑ Unpaid labour for shopping, banking and other errands
Adult day programs	↑ Out-of-pocket costs	↑ Out-of-pocket costs	N/A
Consultation services—impacts will be greater in ON than BC given broader range of services available	↓ Current income ↑ Unpaid labour	↓ Current income ↑ Unpaid labour	N/A
Drug plans	↓ Out-of-pocket costs	↓ Out-of-pocket costs	↓ Out-of-pocket costs
Home oxygen programs	↓ Out-of-pocket costs	↓ Out-of-pocket costs	No out-of-pocket costs
Equipment plans	N/A	↓ Out-of-pocket costs	N/A
Physician and hospital services—impact varies by comprehensiveness of basic health care benefits and premiums	↑ Out-of-pocket costs for basic health care premium ↓ Out-of-pocket costs for more comprehensive health care	No premiums charged ↓ Out-of-pocket costs, but less comprehensive health care	No premiums charged but least comprehensive health care

Profile 4: John, Adult Child Caregiver, Married with One Adult Child at Home, Employed Full Time and Primary Caregiver

Program	Capital Region (BC)	Niagara Region (ON)	Cape Breton Region (NS)
	Caregiver's personal income $43,074	Caregiver's personal income $41,402	Caregiver's personal income $30,095
	Caregiver's family income $69,524	Caregiver's family income $62,246	Caregiver's family income $45,801
	Care receiver's income $20,879	Care receiver's income $16,488	Care receiver's income $13,291
Labour			
Family responsibility leave	Unlikely to impact current income, future income and employment benefits	N/A	N/A
Income Security			
Provincial social assistance programs	CG is not eligible	CG is not eligible	CG is not eligible
Old Age Security	↓ Out-of-pocket costs	↓ Out-of-pocket costs	↓ Out-of-pocket costs
Canada Pension Plan	↓ Out-of-pocket costs	↓ Out-of-pocket costs	↓ Out-of-pocket costs
Guaranteed Annual Income Supplement	CR is not eligible	CR is eligible	CR is eligible
Spouse's Allowance	CR is not eligible	CR is not eligible	CR is not eligible
Provincial income supplement programs	CR is not eligible	CR is not eligible	CR is eligible
Attendant care expenses tax deduction	↓ Out-of-pocket costs	↓ Out-of-pocket costs	↓ Out-of-pocket costs
Caregiver tax credit	CG is not eligible	CG is not eligible	CG is not eligible
Equivalent-to-spouse tax credit	CG is not eligible	CG is not eligible	CG is not eligible
Tax credit for infirm dependants > 18 years	CG is not eligible	CG is not eligible	CG is not eligible
Disability tax credit	↓ Out-of-pocket costs	↓ Out-of-pocket costs	↓ Out-of-pocket costs
Medical expenses tax credit	CG is not eligible	CG is not eligible	CG is not eligible
BC surtax reduction	CG is not eligible	N/A	N/A
NS low income tax reduction	N/A	N/A	↓ Out-of-pocket costs

Profile 4: John (cont'd)

Program	Capital Region (BC)	Niagara Region (ON)	Cape Breton Region (NS)
Health			
Home care	↑ Out-of-pocket costs	↑ Out-of-pocket costs	No out-of-pocket costs ↑ Unpaid labour for shopping, banking and other errands
Adult day programs	↑ Out-of-pocket costs	↑ Out-of-pocket costs	N/A
Consultation services—impacts will be greater in ON than BC given broader range of services available	↓ Current income ↑ Unpaid labour	↓ Current income ↑ Unpaid labour	N/A
Drug plans	↓ Out-of-pocket costs	↓ Out-of-pocket costs	↓ Out-of-pocket costs
Home oxygen programs	↓ Out-of-pocket costs	↓ Out-of-pocket costs	No out-of-pocket costs
Equipment plans	N/A	↓ Out-of-pocket costs	N/A
Physician and hospital services—impact varies by comprehensiveness of basic health care benefits and premiums	↑ Out-of-pocket costs for basic health care premium ↓ Out-of-pocket costs for more comprehensive health care	No premiums charged ↓ Out-of-pocket costs, but less comprehensive health care	No premiums charged but least comprehensive health care

Profile 5: Edith, Primary Caregiver of Her Husband

Program	Capital Region (BC)	Niagara Region (ON)	Cape Breton Region (NS)
	Caregiver's personal income $20,879	Caregiver's personal income $16,488	Caregiver's personal income $13,291
	Caregiver's family income $55,022	Caregiver's family income $43,402	Caregiver's family income $32,851
	Care receiver's family income $55,022	Care receiver's family income $43,402	Care receiver's family income $32,851
Labour			
Family responsibility leave	CG is not eligible	N/A	N/A
Income Security			
Provincial social assistance programs	CG is not eligible	CG is not eligible	CG is not eligible
Old Age Security	No impact	No impact	No impact
Canada Pension Plan	No impact	No impact	No impact
Guaranteed Annual Income Supplement	CR is not eligible	CR is not eligible	CR is not eligible
Spouse's Allowance	CR is not eligible	CR is not eligible	CR is not eligible
Provincial income supplement programs	CR is not eligible	CR is not eligible	CR is not eligible
Attendant care expenses tax deduction	CG is not eligible	CG is not eligible	CG is not eligible
Caregiver tax credit	CG is not eligible	CG is not eligible	CG is not eligible
Equivalent-to-spouse tax credit	CG is not eligible	CG is not eligible	CG is not eligible
Tax credit for infirm dependants > 18 years	CG is not eligible	CG is not eligible	CG is not eligible
Disability tax credit	↓ Out-of-pocket costs	↓ Out-of-pocket costs	↓ Out-of-pocket costs
Medical expenses tax credit	↓ Out-of-pocket costs	↓ Out-of-pocket costs	↓ Out-of-pocket costs
BC surtax reduction	no impact	N/A	N/A
NS low income tax reduction	N/A	N/A	CG is not eligible

Profile 5: Edith (cont'd)

Program	Capital Region (BC)	Niagara Region (ON)	Cape Breton Region (NS)
Health			
Home care	↑ Out-of-pocket costs ↑ Unpaid labour for light housekeeping	↑ Out-of-pocket costs	↑ Out-of-pocket costs ↑ Unpaid labour for shopping, banking and other errands
Adult day programs	↑ Out-of-pocket costs	↑ Out-of-pocket costs	N/A
Consultation services—impacts will be greater in ON than BC given broader range of services available	↑ Unpaid labour	↑ Unpaid labour	N/A
Drug plans	↓ Out-of-pocket costs	↓ Out-of-pocket costs	↓ Out-of-pocket costs
Home oxygen programs	↓ Out-of-pocket costs	↓ Out-of-pocket costs	↓ Out-of-pocket costs
Equipment plans	N/A	↓ Out-of-pocket costs	N/A
Physician and hospital services—impact varies by comprehensiveness of basic health care benefits and premiums	↑ Out-of-pocket costs for basic health care premium ↓ Out-of-pocket costs for more comprehensive health care	No premiums charged ↓ Out-of-pocket costs, but less comprehensive health care	No premiums charged but least comprehensive health care

Profile 6: Ervin, Primary Caregiver of His Wife

Program	Capital Region (BC)	Niagara Region (ON)	Cape Breton Region (NS)
	Caregiver's personal income $34,143	Caregiver's personal income $26,914	Caregiver's personal income $18,808
	Caregiver's family income $55,022	Caregiver's family income $43,402	Caregiver's family income $32,851
	Care receiver's family income $55,022	Care receiver's family income $43,402	Care receiver's family income $32,851
Labour			
Family responsibility leave	CG is not eligible	N/A	N/A
Income Security			
Provincial social assistance programs	CG is not eligible	CG is not eligible	CG is not eligible
Old Age Security	No impact	No impact	No impact
Canada Pension Plan	No impact	No impact	No impact
Guaranteed Annual Income Supplement	CR is not eligible	CR is not eligible	CR is not eligible
Spouse's Allowance	CR is not eligible	CR is not eligible	CR is not eligible
Provincial income supplement programs	CR is not eligible	CR is not eligible	CR is not eligible
Attendant care expenses tax deduction	CG is not eligible	CG is not eligible	CG is not eligible
Caregiver tax credit	CG is not eligible	CG is not eligible	CG is not eligible
Equivalent-to-spouse tax credit	CG is not eligible	CG is not eligible	CG is not eligible
Tax credit for infirm dependants > 18 years	CG is not eligible	CG is not eligible	CG is not eligible
Disability tax credit	↓ Out-of-pocket costs	↓ Out-of-pocket costs	↓ Out-of-pocket costs
Medical expenses tax credit	↓ Out-of-pocket costs	↓ Out-of-pocket costs	↓ Out-of-pocket costs
BC surtax reduction	No impact	N/A	N/A
NS low income tax reduction	N/A	N/A	CG is not eligible

Profile 6: Ervin (cont'd)

Program	**Capital Region (BC)**	**Niagara Region (ON)**	**Cape Breton Region (NS)**
Health			
Home care	↑ Out-of-pocket costs	↑ Out-of-pocket costs	↑ Out-of-pocket costs ↑ Unpaid labour for shopping, banking and other errands
Adult day programs	↑ Out-of-pocket costs	↑ Out-of-pocket costs	N/A
Consultation services—impacts will be greater in ON than BC given broader range of services available	↑ Unpaid labour	↑ Unpaid labour	N/A
Drug plans	↓ Out-of-pocket costs	↓ Out-of-pocket costs	↓ Out-of-pocket costs
Home oxygen programs	↓ Out-of-pocket costs	↓ Out-of-pocket costs	↓ Out-of-pocket costs
Equipment plans	N/A	↓ Out-of-pocket costs	N/A
Physician and hospital services—impact varies by comprehensiveness of basic health care benefits and premiums	↑ Out-of-pocket costs for basic health care premium ↓ Out-of-pocket costs for more comprehensive health care	No premiums charged ↓ Out-of-pocket costs, but less comprehensive health care	No premiums charged but least comprehensive health care

REFERENCES

Barr, J.K., K.W. Johnson and L.J. Warshaw. 1992. “Supporting the elderly: Workplace programs for employed caregivers.” *Millbank Quarterly*. 70(3): 509-533.

B.C. (British Columbia), Ministry of Labour. 1999c. **“**Government revamps regulations to aid high-tech growth: New standards improve workplace flexibility.” News release AE06-99. <http://www.labour.gov.bc.ca/ hightech/02-01-99.htm>.

B.C. (British Columbia), Ministry of Social Development and Economic Security. 1999. *Applying for BC benefits*. November 10. <http://www.sdes.gov.bc.ca/publicat/ fasttrak/b.htm>.

B.C. (British Columbia), Office for Seniors. 1999. *Information for seniors guide: Health services*. April. <http://www.hlth.gov.bc.ca/seniors/docs/info/health.html#acute & continuing>.

Canada, Health Canada. 1999. *Provincial and territorial home care programs: A synthesis for Canada*.

Canada, HRDC (Human Resources Development Canada). 1996. *Division of legislative powers*. <http://labour-travail.hrdc-drhc.gc.ca/policy/leg/e/stand-e1.html>.

———. 1997a. *Employment standards legislation in Canada*. <http://labour-travail.hrdc-drhc.gc.ca/policy/leg/e/stan10-ei.html>.

———. 1997b. *Overview: Income security programs: Old age security, Canada pension plan*. Report # ISPB-100-07-97E. Ottawa.

———. 2000. *The repayment of old age security pension benefits for residents of Canada*. <http://www.hrdc-drhc.gc.ca/isp/oas/oasrepay_e.shtml>.

Canada, Revenue Canada. 1998. *Medical expense and disability interpretation bulletin*. IT-519R2. April 6. <http://www.rc.gc.ca/E/pub/tp/519r2ed/519r2ed.html>.

Canada, Statistics Canada. 1998a. *General social survey, cycle 12: Time use survey*. Electronic database. Ottawa.

———. 1998b. *Statistical profile of Canadian communities.* <http://ww2.statcan.ca/ english/profil/>.

———. 2000. “Labour force update: An overview of average wages and wage distributions in the late 1990s.” *The Daily*. <http://www.statcan.ca/Daily/English/ 000724/d000724b.htm>.

Canada, Status of Women Canada. 1996. *Gender-based analysis: A guide for policy-making*. Ottawa.

CCSD (Canadian Council on Social Development). 2000a. *Urban poverty in Canada: A statistical profile*. April 17. <http://www.ccsd/ca/pubs/2000/up/hl.htm>.

———. 2000b. *Communique: Poverty trends call for new approach in government policy*. July 19. <http://www.ccsd.ca/pubs/2000/fbpov00/pr.htm>.

CARNET: The Canadian Aging Research Network. 1993. *Work and family: The survey. Findings*. Guelph, ON: University of Guelph, Gerontology Research Centre.

Enterprise Cape Breton Corporation. 1998. *An interim economic evaluation of the Cape Breton Retirement Program*.

Fast, J.E. and M. DaPont. 1997. "Changes in women's employment continuity." *Canadian Social Trends.* 46: 2-7.

Fast, J. and J.A. Frederick. 1996. "Working arrangements and time stress." *Canadian Social Trends.* 45: 14-19.

Fast, J.E. and J.A. Frederick. 1999. "Informal eldercare: Is it really cheaper?" Paper presented at the International Association of Time Use Researchers conference, Colchester, England, October.

Fast, J.E. and N.C. Keating. 2000. *Family caregiving and consequences for carers: Toward a policy research agenda*. CPRN Discussion Paper No. F/10. Ottawa, ON: Canadian Policy Research Networks.

Fast, J.E. and M. Mayan. 1998. "Paying for care: Repercussions for women who care. The Canadian case." Unpublished manuscript prepared for the Organization for Economic Co-operation and Development.

Fast, J.E., D. Forbes and N. Keating. 1999a. *Contributions and needs of informal elder care providers in Canada: Evidence from Statistics Canada's 1996 general social survey on social supports*. Final report submitted to Health Canada, Health Promotion and Programs Branch, Health Systems Division. Edmonton, AB.

Fast, J. E., D.L. Williamson and N.C. Keating. 1999b. "The hidden costs of informal elder care." *Journal of Family and Economic Issues.* 20(3): 301-326.

Finch, J. 1986. "Community care and the invisible welfare state." *Radical Community Medicine, Summer.* 15-22.

Gignac, M.A.M., E.K. Kelloway and B.H. Gottlieb. 1996. "The impact of caregiving on employment: A mediational model of work-family conflict." *Canadian Journal on Aging*. 15(4): 525-542.

Glendinning, C. 1992. *The costs of informal care: Looking inside the household*. London, UK: Her Majesty's Stationery Office.

Gottlieb, B.H., E.K. Kelloway and M. Fraboni. 1994. "Aspects of eldercare that place employees at risk." *Gerontologist*. 34(6): 815-821.

Hollander, M.J. and E.R. Walker. 1998. *Report of continuing care organization and terminology*. Report prepared for the Federal/Provincial/Territorial Committee of Officials (Seniors) for the Minister Responsible for Seniors. Ottawa: Health Canada, Division of Aging and Seniors.

Home Care Nova Scotia. 1997. *Policy and procedures manual.* Second edition. Halifax, NS, May.

Joseph, A.E. and B.C. Hallman. 1998. "Over the hill and far away: Distance as a barrier to the provision of assistance to elderly relatives." *Social Science Medicine*. 46(6): 631-639.

Keating, N.C., J.E. Fast, I.A. Connidis, M. Penning and J. Keefe. 1997. "Bridging policy and research in eldercare." *Canadian Journal on Aging/Canadian Journal of Public Policy*. Supplement, 22-41.

Keating, N., J. Fast, J. Frederick, K. Cranswick and C. Perrier. 1999. *Eldercare in Canada: Context, content and consequences*. Ottawa: Statistics Canada.

Lindsay, C. 1999. *A portrait of seniors in Canada*. Third edition. Ottawa: Statistics Canada.

Logan, R. 1994. "Voluntary part-time workers." *Perspectives on Labour and Income*. 6(3): 18-23.

Maatbuis, D. and P. Miller. 2000. "Changes in access to long term care services." *Family Caregivers Network Society*. Spring, 13.

Majchrzak, A. 1984. *Methods for policy research*. Thousand Oaks, CA: Sage.

NACA (National Advisory Council on Aging). 1990. *The NACA position on informal caregiving: Support and enhancement*. Ottawa.

Neal, M.B., N.J. Chapman, B. Ingersoll-Dayton and A.C. Emlen (Eds.). 1993. *Balancing work and caregiving for children, adults, and elders*. Thousand Oaks: Sage.

Netten, A. 1994. *The costs of informal care*. Discussion paper 1094. Canterbury, Kent: University of Kent at Canterbury, Personal Social Services Research Unit.

Ontario, Ministry of Health and Long-Term Care. 1999. *1999/2000 Planning, funding and accountability policies and procedures manual for long-term care community services.* Section 4, Sixth edition. Toronto.

Pal, L.A. 1997. *Beyond policy analysis: Public issue management in turbulent times*. Scarborough, ON: International Thomson.

Parker, G. 1990. *With due care and attention: A review of research on informal care*. London, UK: Family Policy Studies Centre.

Penning, M.J. and N.C. Keating. 2000. "Self-, informal and formal care: Partnerships in community-based and residential long-term care settings." *Canadian Journal on Aging*. 19(Suppl 1): 75-100.

Penrod, J.D., R.A. Kane, R.L. Kane and M.D. Finch. 1995. "Who cares? The size, scope, and composition of the caregiver support system." *Gerontologist.* 35: 489-497.

Rankin, E.D. 1990. "Caregiver stress and the elderly: A familial perspective." *Journal of Gerontological Social Work.* 15(1/2): 57-73.

Ross, D.P., K.J. Scott and P.J. Smith. 2000. *The Canadian fact book on poverty*. Ottawa, ON: Canadian Council on Social Development.

Scharlach, A.E. and S.L. Boyd. 1989. "Caregiving and employment: Results of an employee survey." *Gerontologist.* 29(3): 382-387.

Seniors Serving Seniors. 1998/99. *Seniors' services directory: A community resource handbook for the Capital Region*. Victoria, BC.

Stone, R. 1991. "Familial obligations: Issues for the 1990s." *Generations.* Summer/ Fall: 47-50.

Victoria, Economic Development Office. 1999. *Destination Victoria – Population*. January. <http://www.edo.city.victoria.bc.ca/pubs/destination/population.htm>.

Waring, M. 1988. *Counting for nothing: What men value and what women are worth*. Wellington, NZ: Bridget Williams.

Weinberger, M., D.T. Gold, G.W. Divine, P.A. Cowper, L.G. Hodgson, P.J. Schreiner and L.K. George. 1993. "Expenditures in caring for patients with dementia who live at home." *American Journal of Public Health.* 83(3): 338-341.

NOTES

[1] There is no national body for informal caregivers. Representation of their interests is often fragmented among seniors' advocacy groups, disease-specific associations and peer support groups.

[2] Sons-in-law are unlikely to be significant care providers, in contrast to daughters-in-law.

[3] Adult day programs are discussed in a separate section.

[4] Currently, there are no recipients in this program in Nova Scotia.

[5] A person is eligible for the disability amount if he/she is blind, unable to walk, unable to speak, unable to think, perceive and remember, deaf or severely hard of hearing, unable to feed or dress her/himself, or unable to manage bowel and bladder functions personally.

[6] Certain professions and occupations are excluded from the Act, such as engineers, insurance agents, doctors, optometrists, lawyers, chartered accountants, dentists, real estate agents and veterinarians. High-technology professionals were recently exempted from requirements on hours of work, overtime and statutory holidays (British Columbia, Ministry of Labour 1999).

[7] In Quebec, frail elderly individuals may be granted a limited allowance that permits them to purchase certain homemaking and personal care services or respite care for caregivers, without restriction on whom they hire. This means family caregivers may replace some labour force income (Fast and Mayan 1998). However, full-time employees are less likely than part-time employees to give up their paid work (Glendinning 1992).

[8] For example, Statistics Canada has Low Income Cut-Offs (LICOs) based on size of household and size of area of residence.

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* Some of these papers are in progress, and not all titles are finalized.