

**The Changing Nature of Home Care and Its Impact on
Women's Vulnerability to Poverty**

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with
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for the
Canadian Research Institute for the Advancement of Women (CRIAOW)

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- the original contribution that the report would make to existing work on this subject, and its usefulness to equality-seeking organizations, advocacy communities, government policy makers, researchers and other target audiences

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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 focused 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 eldercare, 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.

ACKNOWLEDGMENTS

The Canadian Research Institute for the Advancement of Women (CRIAOW) would first and foremost like to thank all the participants—the home care recipients, informal caregivers, home care workers, agencies, policy makers, organizational representatives—who agreed to be interviewed for this research. In addition, we wish to acknowledge the Aspen Regional Health Authority, Community Care, in Morinville, Alberta, for providing us with its client satisfaction survey from which we drew some of our questions.

We also wish to thank the researchers and members of the advisory committee who together made up the research team. As in previous CRIAOW research, we have opted for a collaborative model involving multiple researchers, and to locate the research in various regions using local researchers. Marika Morris (Ottawa) was the researcher responsible for the policy analysis and final edit of this paper. Jane Robinson (St. John's) and Janet Simpson (Winnipeg) were responsible for the case studies in their respective locations. Sandra Kirby (Winnipeg) served as an advisor and suggested a number of the recommendations. Lise Martin (Ottawa) was the project co-ordinator and responsible for the literature review. Martha Muzychka (St. John's) was an advisor and editor. A number of interviews for the policy section were conducted by Sherry Galey (Ottawa). The full team had input into the research design. Thanks also to Susannah Bush who worked on the bibliography.

We also thank the Independent Policy Research Fund, Status of Women Canada, for making this research possible, and for recognizing the value and necessity to provide gender analyses of policy.

The views expressed in this paper are those of the authors only.

GLOSSARY

AFEAS	Association féminine d'éducation et action sociale
CAP	Canada Assistance Plan
CHST	Canada Health and Social Transfer
CLSC	Centre local de services communautaires
EI	Employment Insurance
EPF	Established Programs Financing
GDP	Gross Domestic Product
HCSB	Health and Community Services Board
HSW	Home Support Worker
LPN	Licensed Practical Nurse
OT	Occupational Therapist
PCA	Personal Care Attendant
PT	Physiotherapist
RN	Registered Nurse
VON	Victorian Order of Nurses
WCA	Winnipeg Community and Long Term Care Authority
WCB	Workers' Compensation Board

EXECUTIVE SUMMARY

Women form the majority of home care recipients, home care personnel and persons responsible for the care of elderly, disabled or ill family members. The extreme gender imbalance in every aspect of home care means that home care policies and practices have a significant and varied impact on women's lives.

This research builds on previous studies that show women's roles as unpaid and underpaid caregivers contribute to the income gap between women and men. It also examines whether current home care policies and practices have any impact on women's vulnerability to poverty.

Interviews were conducted in St. John's, Newfoundland, and Winnipeg, Manitoba, with home care recipients, agencies, paid workers and informal family caregivers. Interviews were also carried out with experts, representatives of national organizations dealing with home care issues, and federal government officials, mainly in Ottawa, Ontario. A national literature review was also completed on women and home care.

The study concludes that current home care policies and practices do have a negative financial impact on women as home care recipients, paid providers and unpaid caregivers, contributing in many cases to the impoverishment of women. The results were very similar for both St. John's and Winnipeg, despite the different home care systems in each province, and the different population characteristics of these two cities. Thus, there are lessons to be learned from this study for all provincial and territorial programs and agencies.

Specific Findings Included in Study

- Women family members were expected to supplement home care services without pay and at great personal expense in terms of their own health, incomes, benefits, career development and pension accumulation, whereas men were not under as much pressure to do so.
- Home care suffers from inadequate public funding, which leads to barriers in access to subsidized care due to eligibility requirements, inadequate hours of home care being assessed for some clients, limits on hours of care and types of services. This results in recipients sometimes receiving fewer hours of care than needed or than their doctors recommend. The majority of those not receiving the care they needed were women.
- Low wages, irregular hours, inadequate training and high turnover of home care workers resulted in the lack of continuity of care, staff shortages, waiting lists, health risks to both workers and recipients, and impoverishment. Some home care workers had to work several jobs to make ends meet. Others were living below the poverty line. The vast majority were women.

- The “deprofessionalization” of home care work is a problem. Duties that would be performed in a hospital at one wage and by one type of worker are often performed in the home setting at less than half the wage and sometimes by workers who are not qualified to perform the work. The move from institutional care to home care is transforming an overworked and underpaid, mainly female, labour force into an even more underpaid and isolated female labour force. Another aspect of deprofessionalization is that the medical and personal care which family members (mainly women) sometimes provide without medical or attendant care training, which saves money for the state, causes stress and the possibility of mistakes and even injury on the part of the caregiver.
- The absence of professional associations or unions for some home care workers had a direct negative impact on wages.
- The financial costs associated with home care were picked up by recipients, their families or home care workers. Many of these costs would be absorbed by the government if the recipient were in hospital—things such as medical equipment, special meals, renovations to accommodate disabilities, repairs and maintenance of the care setting, in some instances prescription and non-prescription drugs. How much is paid publicly varies by jurisdiction.
- Access to home care depends on where you live in Canada. There is poor (or no) service in rural areas and remote communities. Access to publicly funded service depends on what province you live in—eligibility requirements, maximum hours of service and whether and how much the recipient is required to pay vary.
- Quality control standards, where they exist, are frequently ignored. Some home support workers alone with very ill recipients did not even have the minimum requirement of first-aid training.
- Women are not always aware of respite care, where available, and sometimes fees are associated with respite care, putting it out of reach for some families.
- Inadequate income support programs keep unattached women over 65 and women with disabilities in poverty. These are two of the largest home care user groups and those least able to pick up the costs of private care and other costs.
- Services were not culturally sensitive, leading to under use of services among urban Aboriginal peoples and some ethnic, racial and linguistic minority communities. Women in these communities frequently *are* the home care system.
- Recipients, home care workers and unpaid caregivers all had health, safety and human rights concerns. Some caregivers were subject to violence or harassment by recipients, particularly those living with mental illness; some recipients reported financial abuse and harassment by paid and unpaid caregivers, and physical safety concerns due to the overwork and inadequate training of both paid and unpaid caregivers.

- Recipients and unpaid caregivers reported a lack of control and choices, sometimes even a basic lack of information and communication among agencies, assessment co-ordinators and recipients.
- Although home care was a positive experience and good choice for some, others viewed it as the lesser of evils, due to the state of hospitals and institutions, or the alternative to no care at all.
- Some female home care workers experienced gender bias and stigma.

Recommendations to the Federal Government

- Immediately provide the provinces and territories with funds specifically for home care to ensure access, and large enough to cover psychological support, pharmacare, denticare and other currently privatized costs essential to the health and well-being of elderly, disabled, chronically ill and recovering persons. Restore full rather than partial funding for health care services.
- Work to develop Canada home and community care legislation based on the principles of the *Canada Health Act*, ensuring accessibility, portability, universality, comprehensiveness and public administration. Other principles should include access to co-ordinated, appropriate, publicly accountable and culturally sensitive services.
- Establish a national inquiry into wages and working conditions of home care workers and unpaid caregivers, which will, among other topics, explore the issue of remuneration for caregivers.
- Review income and tax programs and policies to alleviate poverty.
- Work with First Nations, Inuit and Métis peoples on developing good quality, culturally sensitive, accessible home care for Aboriginal peoples in their own communities, including inner-city urban areas.

Recommendations to Provincial/Territorial Governments and, Where Applicable, Regional Health Authorities

- Eliminate any and all fees for service.
- Establish or facilitate provincial professional associations for home care workers for the purposes of accreditation, training, ongoing skills and career development, providing information regarding employer and employee rights and responsibilities, and negotiation of wages, benefits and working conditions.
- Review and streamline the assessment process with a view to eliminating gender bias and ensuring recipients get all the care they need.

- Require any public or private agency receiving public funds for home care to be transparent and accountable to the public.
- Invest in respite care for unpaid caregivers with no user fees, and ensure caregivers are aware of services available and of their benefit to caregivers and, ultimately, the recipient of care.
- Implement the recommendations of the Masuda report on women with disabilities.
- Develop quality standards for home care where they do not already exist. Audit and evaluate home care programs and agencies to ensure standards are being met, with real consequences for agencies that do not comply.

The report also contains recommendations for employers, home care agencies, private insurance companies and trade unions.

1. INTRODUCTION

The promise of a national home care program has sparked a flurry of research and discussion about the shape such a program should take. Although all the provinces and territories have some form of government-funded home care service, there are no common approaches to how services are funded or delivered, or who is eligible, raising important questions about universality, comprehensiveness, portability and accessibility.

While home care is viewed as a desirable alternative to institutional care for meeting the needs of seniors, people with disabilities and people discharged from hospital, the emphasis on home care also stems from cost-cutting policies and the devolution of care responsibilities to the community (Armstrong and Armstrong 1996; Day and Brodsky 1998).

Definition of home care

Home care enables individuals with major or more minor limitations to live at home and/or in supportive housing. Home care services can assist in preventing, delaying or replacing long-term care or acute care alternatives. Such services include professional services, medical supplies, homemaking and attendant care, and maintenance and preventive care. These are currently provided through formal, subsidized, insured or private arrangements as well as by informal caregivers from families, community networks and volunteer agencies.

In Fast et al.'s review of the literature (1997), studies comparing the costs of home versus institutional care conclude that home-based care is cheaper. However, the studies tend to be limited to measuring the costs of care to the public purse. They sometimes assume informal caregiving has no cost, completely overlooking the costs to the informal caregiver and the recipient of care, and the short- and long-term consequences of these costs on public health and the economy.

The financial, social, physical and emotional burdens of home care on informal family caregivers, mainly women, are recognized in some of the literature and by governments, but without much follow-up action to eliminate the burden. Home care systems rely on this unpaid work to function. Even today, women's paid and unpaid labour, having grown from centuries of unpaid work meeting the needs of others, tends to be underpaid and undervalued (Neysmith 1995).

“Economic policy and women's equality rights do not belong in watertight compartments; they cannot be treated as though they have nothing to do with each other. They are integrally connected.”

Day and Brodsky 1998

A gender analysis of home care policies looks at women and men as recipients of home care, paid providers and unpaid caregivers. It considers how home care

issues may affect women and men differently, draws on the perspective of women's traditional caregiving role and clearly articulates equality between women and men as an underlying and essential component of any home care program.

This paper is a gender analysis of home care policies. It looks at home care in the context of women's vulnerability to poverty, and of health cuts and hospital bed closures. Along with the policy perspective, the paper also incorporates data collected from two regional sites reflecting the experiences of providers (formal and informal) and home care recipients. Finally, the paper also proposes and discusses recommendations for change.

The Context of Home Care in Canada Today

In addition to consultation with stakeholders about a national home care program, the federal government is currently involved in home care services in three ways.

- Veterans Affairs Canada offers home care services to recipients with wartime or special-duty-area service when the service is not available to them through provincial and territorial programs.
- A very limited program is offered jointly by Indian and Northern Affairs Canada and Health Canada for on-reserve First Nations home care.
- Block funding to the provinces for health and social services is provided through the Canada Health and Social Transfer (CHST), but no standards of care are set (CHCA et al. 1998).

Otherwise, home care is within provincial jurisdiction and control. As home care is not covered under the *Canada Health Act*, it is not protected in the same way as hospital and physician services. There is a patchwork of home care services across the country with different eligibility requirements, different levels of services, different administrative models, different standards and training requirements, and different costs (Larson 1998).

The Need for a Gender-Based Analysis

Both the federal and most provincial/territorial governments have charters guaranteeing equality between women and men. All have made statements to this effect. Yet in practice,

“I think that everyone could benefit from an increased awareness of the ways that various policies may impact on women.”

Carol Donovan, Senior Policy Advisor, Home Care Development Branch Health Canada (1998)

there is no place where equality goals are spelled out in home care programs. A participant at the home care consultation organized by the federal government in Halifax in March 1998 said the government is “not even paying lip service” to the issue of gender analysis in

home care (Connors 1998). A Health Canada official says a gender analysis is just beginning to be developed as a part of the home care policy work in the department.

A gender analysis of home care starts with these questions, in terms of gender.

- Who are the recipients of home care?

- Who are the providers?
- Who are the informal family caregivers?

The Recipients

More than two thirds (67%) of people receiving home care services are female (Wilkins and Park 1998). One reason women receive more home care could be because they have a longer life expectancy than men, and therefore make up the majority of Canada's seniors. Another possible reason is that women play a caregiving role in the family, so when the caregiver herself develops physical or mental limitations, the family seeks outside help. A third reason is that since women tend to outlive their husbands, they are less likely than men to have a spouse to care for them in old age. Lower income people are also more likely to receive public home care services (Wilkins and Park 1998). Most of Canada's poor are women, thus making them more likely than men to be unable to afford private home care services (Statistics Canada 1995b).

The two largest user groups of home care are seniors and women and men with disabilities (Wilkins and Park 1998). Finally, there is a growing number of post-acute-care individuals needing home care: people discharged from hospital who continue to need medical or other help in the home during their recovery. These three groups—seniors, people with disabilities and post-acute patients are not mutually exclusive. Someone can obviously be a senior with a disability who has been discharged from hospital following a medical procedure. Whatever the reasons, women make up a significant majority of home care users, and their needs as women should be taken into consideration in designing home care policies and programs.

The Paid Providers

Although we do not know the precise numbers of paid home care providers who are female, we do know that the overwhelming majority of health sector workers, except medical doctors, are female (Statistics Canada 1998a). Of the occupations involved in home care provision—nursing, nursing aides, occupational therapists, physiotherapists, nutritionists and homemaking services—we can assume that these are female-dominated, just as in the health care sector at large. In our study, we found that almost all home care workers in Winnipeg and St. John's are female.

According to Aronson and Neysmith (1997), home support workers (HSWs) in metropolitan areas are mainly low-income women, increasingly drawn from immigrant populations. The average hourly rate of pay for home support workers in one study was \$9 to \$12, with limited benefits and conditions inferior to their counterparts in hospitals and nursing homes. In addition, there is a marked discrepancy between official job descriptions and the actual work, with much of the work going unpaid and unrecognized.

Unpaid Caregivers

Almost three million Canadians provided informal care to someone with a chronic illness or disability in 1996. Two thirds of these caregivers work outside the home, 20% report health impacts and 40% incur expenses (Cranswick 1997). Vague allusions to family and

community care obscure the extent, social value and costs of this labour provided mainly by women (Aronson and Neysmith 1997).

Research suggests that “men and women carers meet with different responses from the formal service system as male carers tend to receive more formal support and relief than do women” (Aronson and Neysmith 1997). The costs and stress of home care on unpaid caregivers are high.

Adult daughters’ capacities may be limited by the necessity of paid work, child care or geographical distance, while spouses’ capacities are likely to be influenced by the limitations that come with their own aging; both may be constrained by their lack of training for the work of caring (Aronson and Neysmith 1997).

This preliminary review demonstrates that home care is an issue predominantly affecting women. It is essential to include a gender perspective in the development of home care programs and policies.

The Context of Women’s Inequality and Vulnerability to Poverty

We have not yet achieved a level playing field between men and women in terms of social and economic equality. These socio-economic differences have a direct impact on how home care is maintained and delivered.

Low Wages and the Caregiving Role

Women earn 73% of what men do for full-year, full-time work (Statistics Canada 1998b). Women with disabilities, Aboriginal women and visible minority women earn even less than the average for all Canadian women (Statistics Canada 1995b). *A Statistics Canada survey and analysis found that the primary reason for the earnings differential between women and men is the presence of children, not age, marriage or education* (Statistics Canada 1995a). Men are not expected to choose between their paid job and their children. Nor are they expected to quit their jobs in order to care for elderly or incapacitated relatives.

Family responsibilities are one of the reasons so many women work part time. One quarter of all women with paid jobs work part time, compared with 9% of men with paid jobs. Sixty-nine percent of part-time workers in Canada are female (Statistics Canada 1995b). Not

“The majority of the poor in Canada are female. One in five Canadian women lives in a low-income situation. Those at highest risk of poverty are female unattached seniors, young unattached women, female lone parents, women with disabilities, Aboriginal women and visible minority women.”
Statistics Canada, 1995b

only do part-time workers earn less because of fewer hours, but their part-time status also affects benefit and pension eligibility.

Another way in which women’s care-giving role has an impact on women’s wages is a historical one. It was once a legal and expected

practice in Canada to pay women half of what men earned for the same work, and laws once promoted inequality between women and men in the labour force, rather than equality (Armstrong and Armstrong 1983). As well, over the last century, paid work seen as suitable for women was an outcropping of their “natural” work in the home: minding children and teaching them skills, serving and helping others, nursing sick and elderly people, cooking and serving food, sewing, managing the home and the household accounts, running errands, helping their husbands run a family farm or business, purchasing supplies, dealing with people in the marketplace. Today, over 70% of women in the paid labour force are still concentrated in a few female-dominated sectors, very much related to these traditional roles: health, clerical, sales, service and teaching (Statistics Canada 1995b). The top 10 jobs most common for women according to the 1996 census are retail salesperson, secretary, cashier, registered nurse, accounting clerk, elementary teacher, food server, general office clerk, babysitter and receptionist (Statistics Canada 1998a). Today’s occupational pay scales still reflect the undervaluing of women’s traditional work and skills, work they performed for their families for no pay at all.

No Wages and the Caregiving Role

Women are *still* expected to do caregiving and household work for free, whereas men are not. The 1996 census collected data on unpaid housework and home maintenance, child care and caring for a senior. Women performed significantly more unpaid work in all three of these categories than men. Not only did a higher proportion of women contribute unpaid work to their households, but they did so for longer hours than men (Statistics Canada 1998a).

Whether or not women and men have paid employment, women are expected to pick up the brunt of unpaid work around the home. For example, among wives who worked full time for pay (30 hours or more), 51% spent more than 15 hours per week doing unpaid housework and home maintenance, whereas only 23% of husbands employed full time spent at least 15 hours per week doing housework or home maintenance. Among wives with no paid employment, 70% did more than 15 hours per week, compared to only 36% of husbands with no paid employment (Statistics Canada 1998a).

This expectation that women will work without pay to provide caregiving and housework for others has had a significant negative financial impact, particularly on the current cohort of older women. A group particularly vulnerable to poverty is that of unattached women over 65. Because of women’s longer life expectancy, the majority of seniors are women. Fifty-eight percent of people aged 65 and over, and 70% of those 85 and over, are women (Statistics Canada 1997). Many of today’s older women have spent many years out of the paid labour force, raising children at home, in effect providing their families with a full-time unpaid caregiver. After divorce, death of their spouse or never having married, often because of providing care services to elderly parents, they find themselves alone in old age, with a labour force pattern which has diminished their pension coverage and led them to end their lives in poverty. Fifty-three percent of unattached women over 65 are low-income earners (Statistics Canada 1997).

Although pension reform over the years has led to a dramatic decline in poverty among many seniors, unattached women over 65 have not benefited as much. A considerably higher proportion of women than men relies solely on the public pension system for support (Statistics Canada 1995b) and remain poor. These are not people who have the economic resources to supplement inadequate hours of publicly funded home care with private arrangements.

A brief look at demographics suggests that this grim reality is likely to perpetuate itself for decades to come. The highest proportion of any age and gender group providing more than 10 hours per week of care to seniors is women aged 45 to 64 (Statistics Canada 1998a). Many of these women are providing unpaid work at the expense of their own retirement planning and future income security. Women are paying a very high price for helping others and for propping up the home care system.

Other women particularly vulnerable because of their role as unpaid caregivers for their families are single parents. Women's low wages plus responsibility for dependants equals poverty. Eighty percent of lone parents in Canada are women. Sixty percent of lone-parent families headed by a female are low-income ones, with average incomes \$12,100 less than lone-parent families headed by men. Of people with disabilities aged 15 to 64, 10% of women and 2% of men are lone parents. Fifteen percent of Aboriginal women and 2% of Aboriginal men under 65 are lone parents (Statistics Canada 1995b).

Canada does not have homemaker wages or pensions, as in some European countries. Those who qualify for Employment Insurance get 15 weeks of paid maternity leave and 10 weeks of parental leave at a partial salary level, with a two-week waiting period in which the pregnant woman/new parent is not paid. Although there are proposals to lengthen parental leave, fewer people than ever qualify for it. In particular, part-time workers, who are mainly women, take longer to qualify. Since implementing "reforms," EI claims by women dropped by 20%, compared to 16% among men. (CEIC 1998) There is still a shortage of subsidized, licensed child care (Cleveland and Krashinsky 1998). Changing a child support order is a lengthy, cumbersome and expensive process. Home care policies do not always take into account women's other family responsibilities.

According to a Statistics Canada survey, when matched for age, marital status and education, the earnings of women without children are very close to those of men (with or without children). The presence of children does not cause a decline in men's incomes, but causes a substantial decrease in single and married women's incomes, a gap which is never closed. The study also tracked hours of unpaid caregiving work, and found that women with children spent a substantially greater time in caregiving and housework activities than men with children. The study concluded that presence of children and women's caregiving role in that regard is the major contributing factor to the wage gap between women and men (Statistics Canada 1995a).

It is then not surprising to realize that the two demographic groups of women most vulnerable to poverty in Canada are single mothers and unattached elderly women. The former are still engaged in a caregiving role at the expense of their personal incomes and advancement. The latter are paying financially in their old age for fulfilling societal

expectations in the '40s, '50s and '60s that they would raise children full time at home. Coupled with women's lower wages in female-dominated industries and based on women's traditional roles in the home, the primary reason women are vulnerable to poverty in Canada today is because of their roles as unpaid and underpaid caregivers.

Policy makers have a choice: exacerbate the situation with policies that offload even more unpaid work onto women and lead to job insecurity, "deprofessionalization" and low wages for paid caregivers, or take gender into account when developing home care policies—ideally with a goal to promote equality and, at the minimum, not create further inequality.

The Context of Health Care Cuts

Until 1977, the federal government reimbursed the provinces for 50% of the costs of hospital and medical insurance. From 1977-78 to 1995-96, federal transfers went from a cost-sharing to a block-funding model, with the introduction of the Established Programs Financing (EPF), wherein cash and tax points were transferred to the provinces for health and post-secondary education. Social assistance was delivered through the Canada Assistance Plan (CAP), which set certain standards. In 1989, the federal government made a unilateral decision to reduce cash contributions to the provinces and territories for health and social programs. This decision resulted in a \$42.1 billion withdrawal of funds for the provinces, of which about \$30 billion would have been spent on health.

In 1996, the federal government merged EPF and CAP, collapsing health, post-secondary education and social assistance into one block transfer accompanied by a \$6.2 billion reduction in the cash portion of the transfer. In the 1998 budget, the federal government restored the Canada Health and Social Transfer to a \$12.5 billion cash floor, still \$6 billion short of the pre-CHST cash floor of \$18.5 billion. This cash entitlement will stagnate in spending power from year to year, unless it is increased. The cash portion of the CHST is the only lever the federal government has to maintain the principles of the *Canada Health Act* (CMA 1998a).

In February 1999, the federal government committed \$11.5 billion over five years for the CHST, which the provinces and territories agreed would be used for health care. In addition, the 1999 federal budget injected \$1.4 billion over three years to other health initiatives such as health research, health information, First Nations and Inuit health services, food safety, prenatal nutrition and diabetes (Health Canada 1999).

The Canadian Medical Association (CMA 1999) points out that with this budget increase for health care, in three years we will be back at the total level of health care spending we were at in 1995, even though there will be 2.3 million more Canadians by then, including 444,000 more Canadians over the age of 65.

The response of the Canadian Healthcare Association¹ to the federal budget echoes this concern.

¹ The Canadian Healthcare Association (CHA) is a federation representing provincial and territorial hospitals, regional health authorities, health care facilities and agencies which employ approximately one million health care providers across the country.

While the money allocated for healthcare in this budget may seem impressive (\$11.5 billion over five years), it will only address some of the most critical problems in our publicly funded health system... CHA is deeply concerned about the increasingly severe signs of crisis surrounding our healthcare system, including: a loss of public confidence; the shift in public to private spending for healthcare; disparities concerning insured health services; deficit financing by regional health authorities, hospitals, health facilities and agencies even when prohibited by law to meet their care obligations; critical levels of frustration amongst health providers; and pressing demands such as the Year 2000 problem and responding to the recommendations of the Krever commission.

Let's not forget that the additional \$2.5 billion that is promised in three to four years is just the amount for health that was cut from federal transfers three years ago. This doesn't take into account inflation or a growing and aging population (CHCA 1999).

The other missing link is that many provinces, for whatever reasons, be it budget deficits, political priorities or cutbacks to the CHST, have also cut social assistance programs and services. Income is a determinant of health, with low income highly correlated with poor health, and economic and social policies having an impact on health (National Forum on Health 1997). As frequently repeated in this paper, women make up the majority of those living with low incomes in Canada. The partial restoration of health funding does not scratch the surface of preventive measures needed to contribute to population health and to reduce the overload on home care programs and unpaid family caregivers.

It is unreasonable to suggest that any health care system can sustain such prolonged and deep cuts without real suffering. In addition to reduced accessibility to care, women outnumber men four to one as workers in the health system, primarily because of their concentration as registered nurses, nursing assistants and nursing aides (Statistics Canada 1998a). These cuts have had a profound impact on women, both as the majority of workers in the health system, and the majority of users (AFEAS 1998).

Home care may be viewed as a stop-gap measure, a less expensive band-aid to stop the bleeding of the health care system which has resulted in shorter hospital stays and reduced access to care. In the background information distributed at the National Conference on Home Care in Halifax in March 1998, lower cost was mentioned in two out of three points made about the purpose of home care (CHCA et al. 1998). Almost all the organizations and experts interviewed for this paper (see Appendix A) identified cost cutting as a driving force behind the move to home care. Policy makers have focussed on the benefits of downsizing while ignoring the costs of offloading services to the community (Day and Brodsky 1998).

The successful rhetoric of the shift to community/home care in public policy in Canada has not been accompanied by a corresponding shift in public resources. As a result, the drift actually signifies the privatizing of the costs and work associated with frailty in old age (Aronson and Neysmith 1997).

Canadians are resistant to using home care as an excuse to cut health care budgets. From May 1991 to February 1998, the percentage of Canadians rating our health care system as excellent or very good fell from 61% to 29%. Given a choice, 71% of Canadians wanted health transfers to the provinces restored rather than a new home care program. Eighty-one percent of Canadians supported more money to medicare (CMA 1998b). Home care is not a quick fix for an ailing health care system reeling under two decades of serious cuts. Home care is an integral part of a vibrant, effective, responsive health care system, of which Canadians were once very proud.

It is important that a home care program not rely on the unpaid work of women, not jeopardize women's health, not turn secure, well-paying, unionized jobs for women into low-paid, casual jobs and not serve to impoverish women as users, workers or unpaid care providers. *Gender equality must be an explicit goal in home care policy making.*

2. METHODS

Objectives

The main objectives of the research are to:

- provide a gender analysis of current home care policies;
- identify current gaps in home care policy;
- determine how current policies and practices may be directly or indirectly moving paid caregiving work to the voluntary sector and perhaps thereby contributing to the impoverishment of women;
- determine whether home care policies link with measures such as pension and family policies to contribute to or lessen the vulnerability of women to poverty; and
- document how home care is evolving as the health care system is restructured.

Data Collection

The researchers collected data for analysis from four sources to develop a comparative database. The instruments used to collect the data included:

- conducting an extensive literature review;
- documenting and analyzing existing home care policies from a gendered perspective;
- conducting key informant interviews at the national level with an emphasis on current policy; and
- administering questionnaires in a guided interview format at two regional sites (Winnipeg and St. John's) with three different populations: home care agencies (profit, not-for-profit and volunteer), home care providers (paid and unpaid), and home care clients or recipients.

Winnipeg was chosen for its diversity including a large immigrant population and the largest urban concentration of Aboriginal people in Canada. As well, Manitoba was the first province to introduce a provincial home care program. St. John's was chosen because it is a relatively small urban centre that serves a significant rural population and suffers from out-migration. Both sites have experienced restructuring in health programming and employment opportunities.

Ethical Review

The research project and its proposed methodology, interview questions and consent forms were submitted for review and approval by institutional ethics committees at the University of Winnipeg and Memorial University of Newfoundland in St. John's. Approval for the project as proposed was received from both institutions.

Participant Demographics

Of the 19 persons interviewed for the national or policy portion of this paper, two were academics, one was an author-broadcaster, three were federal government officials involved in developing home care policy and the remainder were representatives of organizations involved in some way in the home care issue. This included home care, palliative care and nursing associations, health clinics and organizations representing persons with disabilities, women, Aboriginal peoples, people living with AIDS and low-income people. Of the organizational representatives, two were men. The remaining interviewees were women. For a complete list, please see Appendix A.

Twenty home care service-delivery agencies and a total of 51 individuals were interviewed from the two local sites (Winnipeg and St. John's). Of the individuals, 30 were home care workers and 21 were home care recipients. The home care workers were divided further into paid (17) and unpaid (13) workers. Our regional and gender breakdown is shown in tables 1 and 2.

Sixteen of the 51 home care recipients, paid workers and unpaid caregivers interviewed were of English, Scottish or Welsh ethnic or cultural background or ancestry, and the other 35 identified themselves as Ukrainian, Aboriginal, Irish, French, Jewish, Polish, Filipino, Dutch, German or of mixed backgrounds, including, in some cases, English as part of a multiple ethnic background.

Table 1. Participant Demographics in Manitoba and Newfoundland and Labrador

Participants	Manitoba			Newfoundland			Both sites
	M	F	Total	M	F	Total	
Paid home care worker	2	5	7	2	8	10	17
Unpaid caregiver	2	5	7	2	4	6	13
Care recipient	3	8	11	4	6	10	21
Gender totals	7	18	25	8	18	26	51

Table 2. Profiles of Agencies Interviewed

	Winnipeg	St. John's area
For profit	4	7
Private not for profit	2	1
Public	2	1
Volunteer	2	1
Total	10	10

Gender Analysis Method and Process

The federal government made a commitment to examine all its proposed policies, programs and legislation using a gender analysis process (SWC 1995), and has developed gender-analysis guidelines for policy developers (see SWC 1996; Morris 1997a, b). This paper has adapted these guidelines to the home care issue (Appendix B). However, the guidelines pose some questions only policy developers and implementers in government can answer. Therefore, this paper seeks to answer some questions, while providing suggestions as to the process governments can use to answer others.

We specifically looked for gender-disaggregated data in our literature review, and asked about gender and gender-related issues in our questionnaires for all men and women interviewed. We analyzed our data using our knowledge and research on the economic and social differences between women and men.

Selection Process

The policy analysis portion of this paper uses information provided by 19 national organizations and experts who agreed to be interviewed, and recent research materials on home care policy and practice. To identify interested organizations, we looked first at the participant list of the National Conference on Home Care, in Halifax in March 1998. Not all of those contacted agreed to be interviewed. To supplement this list, particularly to fill in demographic gaps such as immigrant and visible minority women and women with disabilities, we searched for persons with expertise in home care, who had done research, outreach or advocacy work on behalf of these respective groups and who were themselves members of these communities.

“ Gender-based analysis is an important part of a comprehensive social/economic analysis of public policy. It takes into account social and economic differences between women and men at every stage of policy development to ensure that:

- potential differential impacts of policies, programs and legislation on women and men are discovered; and
- existing and proposed policies have intended and equitable results for women and men....”

Morris 1997a

Regional participants were recruited in two different ways. Home care agencies were recruited using lists provided by government departments and through publications such as advertisements in the Yellow Pages™ and seniors' guides to services. For each agency, an initial phone call was made to inform management that a letter was forthcoming describing the proposed research. A follow-up phone call was made to those agencies that agreed to participate. The researcher scheduled an interview, at the beginning of which the research protocol and the confidentiality issues were reviewed and any questions were answered. After that, the researcher and the participant signed the consent form.

Home care providers and recipients were recruited through agency referrals, using snowball sampling, word of mouth, advertisements in community bulletins or newsletters, and public bulletin board notices. The researchers contacted those providers or recipients obtained through referral only after the referring contact had informed them of the research. Self-identified participants contacted the researchers directly.

Site Profiles

Winnipeg, Manitoba

The Manitoba Home Care Program was established in 1974. It was the first province-wide, co-ordinated, continuing care program to be developed in Canada. The program was developed in response to recommendations suggesting that alternatives to expensive hospital care be developed (Shapiro 1997).

Manitoba Health administered the program until 1997, when regional health authorities assumed control. Until 1997, government employees provided the assessments, and some service delivery. Contracts with the Victorian Order of Nurses (VON) to provide short- and long-term nursing care, and home support were established, as well as contracts for the provision of backup care, rehabilitation therapy and oxygen therapy. The Winnipeg Community and Long Term Care Authority (WCA) assumed control of home care services in Winnipeg on April 1, 1998.

In February 1996, a leaked Treasury Board document outlined a plan to privatize the home care system, starting by contracting out services provided by its personal care workers. In April 1996, the unionized personal care workers went on a five-week strike to challenge the government's decision to contract out home care services. The agreement which ended the strike provided job security for the current work force for a two-year term, privatization of 20% of personal care services and an evaluation of the experiment within two years (Shapiro 1997; Smith 1996).

In May 1997, Olsten Health Services was awarded a government contract to provide nursing, personal care assistance and home support services to new long-term care recipients in two quadrants of Winnipeg (Manitoba Health 1998). The contract expired in 1998, and a review of cost and quality of service has been completed; however, results have not yet been released.

The WCA accepts referrals into the home care program from any source, including self-referral. Short- and long-term care are provided without charge based on assessed need. Case co-ordinators determine the need for both home care and personal care providing a single entry into the system. On intake, a case co-ordinator, who is a nurse or social worker, makes an appointment to meet with the recipient or family, or both. The case co-ordinator completes a comprehensive assessment, which includes medical needs, and determines the functional and social support status of individuals referred to the program. Available family and community supports are considered in determining the amount and type of services to be provided. Information received is confirmed with the physician and family members. Additional assessments by therapists may also be requested.

A written care plan is developed with the individual (and family), and is reviewed and updated when necessary. The care plan is designed to meet basic, minimal needs, and the recipient and family are directed to sources that could provide care beyond these basic needs. An appeal process is in place for those who have requested home care services and disagree with the decisions regarding eligibility for home care or level of service. Case co-ordinators will provide assessments in the hospital prior to discharge, or in the recipient's home, depending on the particular circumstances.

The following services may be provided, based on recipient need: personal care assistance, home support, health care (including nursing, physiotherapy, occupational therapy and health teaching), family relief, respite care, supplies and equipment, adult day programs, volunteer services (Manitoba Health 1997).

Specialty programs available include the following.

- Self-managed care/family-managed care program: after assessment of need, the case co-ordinator can provide direct payments (instead of services) to persons who wish to self-manage their care. This allows the recipient to control who provides service as well as when it is provided, making it more flexible for individual needs.
- Home oxygen therapy program.
- Community intravenous therapy program.
- Clustered care/supportive housing, e.g., Ten Ten Sinclair/Housing with an Independent Difference (HIDI) project: this enables individuals to co-ordinate attendant care allowing for greater coverage than if living in separate homes.
- Palliative Care Program (CHCA et al. 1998).

Although there is no charge for home care services for those eligible, there may be fees associated with community support services (e.g., adult day programs, facility respite care). In 1997-98, the total number of persons registered with the program in Manitoba was 30,257, an increase of 11% since 1996-97. Individuals accessing care through the program are requiring increasingly complex and intensive professional and personal care (Manitoba Health 1998).

St. John's, Newfoundland

Professional home care services began in St. John's in 1978 when St. John's Home Care was founded for the purpose of improving hospital bed use by providing professional nursing care in individual homes. Implementation of home support services began in Newfoundland and Labrador in 1984, to help people stay home as long as possible to delay institutionalization.

In the St. John's region, the provincial government contracted with companies to deliver home care. The growth in home care (including home support) was such that the government was able to reduce some nursing home beds and close some homes for persons with disabilities. Since 1984, the budget for home support alone has increased from \$1 million to \$30 million. The number of home support workers in the province has increased to 2,000 in 14 years.

Before 1994, a federal-provincial program provided up to two or three hours per day of free basic assistance to about 800 seniors, cost shared under the Canada Assistance Plan. It was available to those who received the Guaranteed Income Supplement (the poorest seniors).

A restructuring of the provincial health care system led to the creation of six community health boards in 1994. A single-entry system was introduced in each region of the province, along with a new financial assessment for long-term care, based on a social assistance standard. Federal income support was no longer used as a screening tool for seniors' home care. Access to nursing homes was also streamlined and became non-denominational. Home care services became available more evenly across the province. The government identified the geographic distribution of seniors and realigned budgets accordingly. In the St. John's region in 1996, there were 17,075 men and women over age 65. If the proportion of women is the same as it is province-wide (57% of the population over age 65), then the gender breakdown of seniors in the St. John's region would be 9,733 female and 7,342 male. Only 1.2%, or 203, of them currently qualify for subsidized home care.

The shift from CAP to the CHST, and accompanying cuts in federal transfer payments, also contributed to major changes in home care delivery in the province. As one home care worker in our study put it:

Clients lost a lot of hours when the CHST replaced CAP.

If approved, seniors can get up to \$2,268 of home care per month. This does not cover professional nursing care. Nursing, physiotherapy, social work and occupational therapy are provided by the Health and Community Services Board (HCSB). Public health nurses make home visits in urban and rural areas. However, there are long waiting lists for physiotherapy and occupational therapy. People who have insurance usually use it for the latter professional services.

The greatest need is for the 18 out of 20 seniors in our community who don't receive care and only need two to three hours per day. It would provide employment and eliminate an awful lot of stress on seniors.

Home care worker in rural Newfoundland

The Continuing Care division of the HCSB administers the assessment of seniors for long-term care, including home care and institutional placement. The Family and Rehabilitative Services division administers the assessment of people with disabilities. Once the seniors or persons with disabilities are approved for subsidized care, they can either hire a worker independently (self-managed care) or engage an agency to provide the care.

Responsibility for people with disabilities remained with the Department of Social Services until 1998 when Family and Rehabilitative Services was integrated with the HCSBs. Inconsistencies in the assessment process and philosophical differences in approach are being worked out. A provincial standard appeal process for home care assessments is being developed.

We went on strike because we wanted better working conditions. We were doing work we shouldn't have been doing, like shovelling, washing walls and painting. If you hurt yourself, they'd say it wasn't in your job description, and it wouldn't be covered by compensation.

Home care worker, Southern Shore

In 1996, home support workers at two agencies in the St. John's region went on strike for better wages and working conditions. Wages were \$5.57 per hour. The two agencies, Comcare (private for-profit) and the Southern Shore Home Support Agency (not-for-profit) eventually closed down and Comcare left the province. The strike finally ended in October 1997 when the provincial government reached an agreement with the workers.

The issue of labour rights of workers in self-managed care situations continues to be contested in the province. An August 1998 Supreme Court decision in Newfoundland granted consumers, their families and advocates the right to be considered employers of home support workers. However, it also upheld the right of home support workers to unionize. Advocates for people with disabilities who fought the case said that unions had no place in private homes.

The Newfoundland Association for Public Employees is appealing the case to the Supreme Court of Canada, to ascertain the rights of workers in the individual home or workplace. The results of this decision will affect the viability of the self-managed option in the province. Provincial government officials said they cannot set standards for the self-managed sector until this case is settled.

3. LITERATURE REVIEW

The literature review focusses on home care and women's vulnerability to poverty. As the literature related to home care is expansive and crosses several academic disciplines, we chose to concentrate on the links between home care, gender and the changing role of the state, as well as on the three groups central to our study—unpaid and paid caregivers, and the recipients of care. It should be noted, however, that the literature pertaining to unpaid caregivers is better developed than for other groups. Since the nature of home care and its impact on women are changing rapidly, we have limited the review to selected Canadian material published after 1990.

Paid Providers of Home Care

The literature paints a bleak view of the status of paid home care providers: as with many other occupations which involve caring activities, and are traditionally dominated by women, home care work is characterized by low pay and low status. This can be compounded by gender, race and class origin (Aronson and Neysmith 1996).

Aronson and Neysmith (1996) found that by not being included in job descriptions, the aspect involving the traditionally female role of caring is virtually invisible and viewed as “non-work.” Virtually all home support workers interviewed had been referred to as “the cleaning lady,” despite their training and actual job demands.

Home care workers often perform work that is outside their formal job descriptions. Although part of this work is done by moral obligation, many workers are in vulnerable positions with few options (Aronson and Neysmith 1996). Of concern as well are the increasing responsibilities being placed on home care workers and the need for them to perform multi-faceted jobs. The Canadian Home Care Association (CHCA et al. 1998) identified the need to provide education and training to home care workers as a priority. Workers must not only handle complex equipment and situations but are also expected to teach these skills to volunteer caregivers. Other issues the Association identified as requiring further attention are the risks involved in this type of work, workplace abuse, the need to fit into the family, and multi-sectoral and interdisciplinary approaches to service delivery.

Labour unrest in the home care sector is expected to rise as unionized jobs are deprofessionalized, and workers are expected to do more with less pay (CHCA et al. 1998).

Neysmith and Aronson (1997) interviewed 30 immigrant women from the Philippines and the Caribbean who were home care workers. They studied how tensions related to this type of work are compounded when the worker is visible as both an immigrant and a woman of colour. Although these women were often treated as people with a low educational level, the reality was that many were professional health care workers before immigrating to Canada. The women provided examples of racism during the course of their work and of how some chose to ignore it while others challenged it. In this particular study, the two employer

agencies had no particular policy on racism; however, the supervisors (all white) called for a broad policy which would give them more power in relation to racist clients.

Unpaid Providers of Home Care

In her review of health care policy, Chappell (1993) quotes a study by the World Health Organization that indicates that irrespective of country, between 75% and 85% of the care received by seniors is provided through informal networks. The literature confirms that, in Canada, most caregiving is done by women, usually wives, daughters and daughters-in-law (Kaden and McDaniel 1990; MacLean et al. 1998; Vézina and Roy 1996; Sky 1996).

The literature also demonstrates a difference between the types of caregiving activities carried out by women and those carried out by men. In their study of caregiving and care receiving, Kaden and McDaniel (1990) found that the wives and daughters provided the bulk of the more demanding daily and weekly caregiving assistance. Husbands and sons were more likely to help with sporadic tasks. The breakdown for daily and weekly assistance from spouses was 77% from wives and 23% from husbands. With children, the breakdown was 87% for daughters and 13% for sons. As the authors indicate, “family caregiving” is a euphemism for wives and daughters. In a survey of eight organizations (396 women and 316 men), elder care was significantly related to family responsibilities interfering with work for women but not for men (Gignac et al. 1996).

Cranswick (1997) looked at the effects of caregiving on caregivers and assessed how well they were coping, based on data from the 1996 General Social Survey. Despite the obvious gender breakdown of unpaid caregivers the author concluded that caregiving is not associated with a specific type of person. Although “help” is broken into two categories, there is no gender-based analysis of what is done by whom and to whom. When looking at how volunteer caregivers coped with balancing caregiving with work and family responsibilities, the author highlighted the fact that 46% rarely felt stressed while 15% always felt this way. She could have highlighted the fact that stress was a frequent factor for 39% and a constant factor for 15% (total: 54%). Although she concluded that women were minimally more burdened than men, she did not look at the intensity of the care provided nor as such other variables as age, number of children and marital status. Interestingly, Cranswick’s study (1997) stated that 55% of women and 45% of men reported repercussions at work, while 27% of the women and 12% of the men reported changes in their health. In contrast, Sky (1996) referred to volunteer caregivers as the “conscripted work force”: the end results for most of the unpaid caregivers she interviewed were isolation, poverty and depression.

In a study based on focus group discussions with 42 unpaid palliative-care caregivers, MacLean et al. (1998) identified the following common themes.

- Although the decision to provide volunteer caregiving was often couched in terms of a “loving choice,” for many there was an element of compulsion.
- The demands on them were overwhelming: many mentioned the lack of sleep and the stress added by the need to carry out medical tasks.

- There were definite financial costs involved. Some quit their jobs, some sold their homes, some went on social assistance. Costs continued beyond the death of the loved one.
- There was a great deal of social isolation.
- Negotiating care and deciding to make use of home care were difficult.

In this same study, the following gaps were identified: lack of information on how the illness was progressing, lack of consistency as a result of high staff turnover and the expectation to act as a case manager within a system which offers little flexibility. Of interest as well in this study is the fact that although 38 of the 42 participants were women, there was no gender-based analysis.

In its review of the impact of home care on family caregivers, the VON of Canada (1997) indicated that loss of control, autonomy and lack of sleep were most often cited as the biggest changes by caregivers. Although respite care is often cited as a need by volunteer caregivers (Sky 1996), it would appear as though it is often not taken advantage of (Chappell 1993).

When looking at the cost of home care to unpaid caregivers, it is important to consider economic costs in the form of expenditures as well as costs related to emotional and social well-being. In addition to the loss of income through foregone employment, there is also the loss or reduction of employer-sponsored benefits, Canada Pension Plan credits, training opportunities, experience in one's field and promotions (Fast 1997). Gignac et al. (1996) confirmed that for those most affected by family interference with work (mainly women), tensions between their elder care and paid work responsibilities resulted in job dissatisfaction, absenteeism, work interruptions and extended absences as well as possible career costs through foregone promotions and restricted opportunities. As a result of their findings, the authors suggested that organizational or community interventions that prevent or limit the extent of elder care's intrusion on work may substantially reduce the adverse effects experienced by caregivers.

In a study which interviewed 246 women caregivers in the work force (15 or more hours per week), the economic consequences such as loss of salary, financial assistance and restriction on ability to save for retirement contributed significantly to their levels of stress (Keefe and Medjuck 1997). Stress level was correlated to the caregiver's income level. The authors emphasized the importance of workplace policies and public policies which "speak to the short term and long term consequences of caregiving on women's lives." The authors point to emerging "family friendly" policies that may have short-term beneficial consequences but long-term negative consequences, encouraging women's economic dependency.

Keefe and Fancey (1997) undertook interviews of 136 unpaid caregivers to look at financial compensation programs and home help services available to them. At the time of their study, there were three Canadian financial compensation programs in existence. This study focussed on the Nova Scotia Life Support Program. The study found that those receiving

financial compensation were more likely to be younger women living with their care receiver in the non-urban areas of the province. Those receiving home help services were more likely to be sons or spouses living in urban areas. The authors attributed the larger proportion of people receiving financial compensation in rural areas to the lack of availability of home help services in these areas. Those receiving financial compensation usually worked between 30 and 40 hours a week at caregiving activities, and tended to perform a higher number of tasks and spend a greater number of hours performing these tasks. The financial reimbursement received was approximately \$88 per week. The authors contrasted this particular scheme to programs in Scandinavia, where caregivers are reimbursed actual market wages and receive regular employment benefits such as vacation and pensions. Although the authors viewed this compensation program as a first step in valuing women's unpaid work, they do mention concerns that these programs may keep women in underpaid caring work in the home. Finally, the authors identified three major improvement areas for the program:

- the removal of stringent eligibility criteria;
- increased compensation; and
- greater availability of financial compensation in tandem with home help services.

Several authors have called for the involvement of unpaid caregivers in policy development, indicating that volunteer caregivers are presently treated separately from, and largely ignored by, the public sector (Chappell 1993). The VON (1997) called for a thorough assessment of the caregiver as well as the recipient when developing a plan of care and the need to include physical and mental status as well as the ability to assume additional costs. It has also recommended that:

- financial assistance be provided to those forced to leave work or to reduce their hours;
- resources be allocated to community-based health support services; and
- employers develop benefit plans to assist employees with their primary caregiving responsibilities.

Recipients of Care

Despite the fact that recipients of care should be at the centre of many of the current discussions on home care, they are often absent in the literature. Drawing on data from the National Population and Health Survey, Wilkins and Park (1998) looked at the characteristics of those receiving publicly funded home care services. In 1994-95, 36% of home care users were under the age of 65. Two thirds of home care recipients were women, largely due to the fact that women have longer life expectancy, suffer from chronic conditions and need greater assistance with daily activities (in comparison to men who have their wives to perform these tasks when they are the ones in need of care). This same study noted that there were significantly more seniors receiving home care than in institutions and

that there was a clear inverse relationship between household income group and the percentage of people receiving home care.

Kaden and McDaniel (1990) compiled a similar profile. Their data revealed that low income was directly related to formal home care service use by women. The authors pointed out that low income is a structural factor of women's old age and, for this reason, women's economic dependency must be addressed in addition to age- and gender-related needs for formal assistance. Public policy must address the income insecurity of older women rather than "building in" their economic dependency into formal support programs, where they are vulnerable to program cuts and fees for service (Kaden and McDaniel 1990).

Becoming dependent on one's children is a situation that most older people wish to avoid; however, it is women who are most likely to find themselves in this situation (Kaden and McDaniel 1990). As a result of focus groups with various stakeholders, Harlton et al. (1998) found that policy makers were convinced that the best care comes from those closest to the older adult. Older adults, however, did not share this view as they felt the use of public or other paid services provided them with more control.

Home Care and the Changing Role of the State

Numerous studies have examined the cost effectiveness of home care, focussing on hospital patient-days saved and the related financial cost savings to the state. We did not find any study which measured the short- and long-term financial, emotional and health costs of home care to paid and unpaid caregivers and recipients.

Hoppe and Mattson (1996) reported on a joint project between Seven Oaks General Hospital in Winnipeg and We Care Home Health Services, a private provider of community-based home health services. This project enabled hospital patients to be discharged earlier with appropriate services and supports in place. Services in the home were provided until the provincial home care program could be implemented. As well, services necessary for discharge, but not offered by the provincial home care program, were also provided. In the three-month period of the project, 340 actual patient days were saved, and another 116 potential days saved were identified. Providing care outside of the hospital enabled a cost savings of 40% as compared to costs for the same services provided in hospital. Results of the project indicated that this was an effective method of making efficient use of acute care beds. Reported patient satisfaction level was high. "The key patient outcome of the project was comprehensive, responsive and flexible care provided in the comfort of their home environment."

Similarly, DeCoster et al. (1996) found that "significant resources in the acute hospital sector are directed towards delivering care to patients that could more appropriately be cared for in an alternative setting." They recommended that the alternatives, such as long-term home and outpatient care, "have to be in place and readily accessible."

However, not only are the appropriate alternative services not always in place, they frequently rely on the unpaid labour of women to function at all. With the downloading of

social services resulting from cutbacks in the CHST, families (i.e., women, as the literature demonstrates) are increasingly responsible for child care as well as elder and palliative care, post-operative care and care of those who are physically and mentally disabled (Day and Brodsky 1998).

With the introduction of the *Budget Implementation Act* in February of 1995 and the resulting CHST, the federal government's ability to create and maintain coherent and equitable standards for social programs has been severely weakened (Day and Brodsky 1998). The government has placed itself in a situation that will make it extremely difficult to introduce a national home care program, despite the fact that the National Forum on Health (1997) strongly advocated for such a program. The current devolution of responsibility increases the likelihood of a program that lacks in consistency, accessibility and eligibility (CHCA et al. 1998).

The changing nature of home care is consistent with the trend toward shifting responsibility from governments to individuals (Armstrong and Armstrong 1996; Day and Brodsky 1998). While home care is being presented as a more "loving" means to deal with frail and elderly persons, the cost-cutting demon seems to rear its head whenever home care is mentioned. The Canadian Home Care Association cites the example of the Alberta government which, several years ago, cut \$749 million from health care, but added only \$110 million (about a seventh of what was cut) to community care.

Ideas such as "self-help" and "community settings" are being used by governments to justify the restructuring measures taking place in the health sector, which are, by and large, affecting the women who are the main workers, both paid and unpaid (Armstrong and Armstrong 1996). Neysmith (1995) states that health care policy seems to be second to fiscal restraint priorities, regardless of the long-term costs of underfunding the health system.

Fast et al. (1997) indicated that policy makers who have concluded that volunteer caregiving is a fiscally responsible alternative, have tended to base their decisions on incomplete information regarding the cost side of their cost/benefit analysis. In particular, it is based on the assumption that caregiving is costless, and on a narrow view of the costs to the formal system (i.e., health and lost income or tax revenue from unpaid caregivers are not included in the analysis).

McDaniel and Gee (1993) examined the contradictions of various policies as they pertain to caregiving. They argued that demographic ageing is a challenge not so much because of its impact on the public purse, but because of its occurrence within the context of family changes, value adjustments and gender differences in life expectancy. They wrote that the Canadian welfare state is characterized by a lack of co-ordination that explains why policies concerning aged persons, and caregiving have developed in an ad hoc, often contradictory, fashion.

Neysmith (1991) argued that the separation of family life, labour market activity and state responsibility results in a segmented and fractured discussion where the needs of the elderly population are in opposition to those of the younger generation. This results in a socially constructed intergenerational conflict when, in reality, it is a public versus private conflict.

In separating the public from the private, the family from the state and production from reproduction, social policy hinders the development of models of care which recognize care as a public service and a right, rather than a family responsibility (Neysmith 1991).

It has been suggested that it may be useful to compare caregiving to elders with child care as it may serve as a possible catalyst for further understanding the interconnections between family, gender and work (McDaniel and Gee 1993). Much like the promises of a national child care program over the decades, the national home care promise may also be set aside.

Day and Brodsky (1998) argued that we must develop a vision that connects social and economic policy to women's rights and equality. The case of home care and its impact on women, is a perfect example of where this vision can be applied.