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HOME CARE SECTOR IN CANADA: ECONOMIC PROBLEMS

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TABLE OF CONTENTS

SUMMARY

This document explores several complex demographic and economic issues relating to the home care sector, and highlights certain questions requiring study and, ultimately, collective decisions.

The document shows that massive reliance on informal caregivers to shoulder responsibility for those who are experiencing decreasing independence entails considerable costs, not only for the informal caregivers themselves, but also for businesses, governments and society. It then provides an overview of federal tax measures aimed at reducing the financial burden on informal caregivers and on persons with decreasing independence. These measures are targeted primarily at the neediest members of society.

The principal human resources problems of the home care sector are also discussed, in particular the workers' poor pay and difficult working conditions, as well as insufficient access to training. These problems may adversely affect both the supply and the quality of home care.

The document briefly sets out the most recent proposals to improve the supply of home care in Canada. It also outlines the measures that would be necessary to offer adequate home care to all citizens and to fund that care, in light of the forecast growth in demand and the demography of informal caregivers. A greater professionalization of home care supported by adequate funding may be desirable, but the means of achieving this remain to be determined. Models adopted by other countries may inspire the development of a Canadian model.

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INTRODUCTION

Over the coming years, one of the greatest challenges confronting the Canadian health care system will be the steep increase in the proportion of people likely to find themselves in a dependent situation[(1)] or in a state of decreasing independence. Although people may experience a loss of independence at any time, the likelihood greatly increases with age, in particular after 80 years of age.[(2)] According to Statistics Canada's most recent demographic projections,[(3)] one person in five will be aged 65 or older in 2026, as opposed to one in eight in 2000. The age group that will grow most rapidly will be that of people aged 80 or older: it will more than double, increasing from 920,000 in 2000 to 1.9 million in 2026.

In Canada, as in most industrialized countries, home care is increasingly becoming the most prevalent means of providing care to persons with decreasing independence, and those suffering from a temporary disability or a chronic illness. Over the past 20 years, home care expenditures in Canada have grown exponentially. In 2000-2001, those expenditures (public and private) totalled nearly $3.5 billion.[(4)] These are conservative estimates, given the difficulties associated with gathering such data in Canada, and they do not take into account the

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(1) A person is said to be "dependent" when he or she needs a high level of assistance to perform "essential acts of life" such as personal hygiene, feeding himself or herself, getting around and doing housekeeping, on a permanent basis, i.e., according to all probability for at least six months.

(2) Laurence Assous and Ronan Mahieu, *Le rôle de l'assurance privée dans la prise en charge de la dépendance : une perspective internationale*, Department of Employment and Solidarity, France, November 2001.

(3) Statistics Canada demographic projections for the 2000-2026 period, *The Daily*, 13 March 2001 (http://www.statcan.ca/Daily/English/010313/q010313a.htm).

(4) Health Canada, *Health Expenditures in Canada by Age and Sex, 1980-81 to 2000-01 – Statistical Annex*, August 2001, Provincial and territorial government and private sector expenditures.

volunteer work done by thousands of informal caregivers throughout the country and the expenses they must incur.

Home care is and will remain an unavoidable and complex component of the health care system. Its complexity is due to a number of factors. Since home health care is not insured under the *Canada Health Act* and is thus not subject to the five principles of health insurance, its organization and delivery vary much more from one province to another than do insured medical and hospital services. Today, federal and provincial home care programs are a blend of health care services and social and support interventions that have developed differently in different parts of the country.(5)

This is the context for the following study of the various economic problems that the home care sector must resolve in order to meet current and future demands. The first two sections discuss the privatization of health care costs through the provision of home care, and its consequences for various sectors of the economy. The third section discusses federal tax support measures for informal caregivers, and the fourth reviews the challenges facing the sector with regard to human resources. The fifth section concerns the demography of informal caregivers and the professionalization of home support services. Finally, the last section provides an overview of the need to sensitize Canadians to the issue of loss of independence and its consequences, and looks at possible reform of the funding of home care in Canada.

HOME CARE AND THE PRIVATIZATION OF HEALTH CARE COSTS

For the past few years, large investments in home care and community services, together with the shift toward ambulatory care, reflect a certain concept of health care delivery. From a strictly financial perspective, home care in some cases is considered to be less costly than institutional care, which explains why provincial governments have increasingly opted for this type of care delivery. The "profitability" of the public home care network, which has supported

(5) For a review of public home care programs in all Canadian provinces, see P. Le Goff, *Home Care in the Atlantic Provinces: Structure and Expenditures* (PRB 02-30E), *Home Care in Quebec and Ontario: Structure and Expenditures* (PRB 02-31E) and *Home Care in Manitoba, Saskatchewan, Alberta and British Columbia: Structure and Expenditures* (PRB 02-32E), Parliamentary Research Branch, Library of Parliament, October 2002.

the shift to ambulatory care and reduced the demand for institutional care, is, however, based on the massive participation of unpaid care providers.

The development of public programs for providing home care brought with it a requirement for greater private-sector participation in funding and delivering health care. In many cases, the early discharge of patients from hospital means that certain health care services, such as prescription drugs, and certain medical devices or equipment usually provided by public hospitals, are now paid for by the patients or their families. Part of the cost of health care and of the burden of providing that care is thus passed on to the beneficiaries, their families, and other unpaid informal caregivers.(6)

Today, all the provinces set limits on the amount of publicly funded home care a beneficiary may receive. The majority of provinces also impose user fees, proportional to the client's income, for home support services. Finally, several provinces depend on the use of private-sector services by wealthier clients in order to cope with the demand, which is greater than the resources available in the public system. Indeed, British Columbia, Nova Scotia and New Brunswick take into account the fact that a client may have private insurance that covers all or part of home support services that he/she needs when they assess the level of public services that he/she may receive.(7) In Quebec, the provision of income tax credits to allow patients to stay at home encourages patients to seek health care outside the public system.

The imposition of fees for home support services for wealthier clients, the priority given to needier clients in allocating public resources and the recourse to private resources to supplement scarce public resources are all evidence of the existence of a two-tier system. Although all nursing care is in theory free for all within the framework of public home care programs, the fact remains that the scarcity of resources and the length of waiting lists cause many people to call on private services outside of the public network.

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(6) J. E. Fast, D. L. Williamson and N. C. Keating, "The hidden costs of informal elder care," *Journal of Family and Economic Issues*, Vol. 20(3), fall 1999.

(7) Health Canada, *Provincial and Territorial Home Care Programs: A Synthesis for Canada,* June 1999, p. 26.

THE COSTS OF PROVIDING VOLUNTEER HOME CARE TO PERSONS WITH DECREASING INDEPENDENCE

Today, most home care (75 to 90%)[8] is provided by family members, most often women. Even though this has some direct advantages, in particular for governments and beneficiaries, the volunteer work of informal caregivers is costly in several respects and is not always the best solution from the economic point of view.

A. Volunteer Activity Worth at Least $5 Billion

In 1996, 11% of Canadians[9] provided care to at least one senior. Of that number, women spent an average of five hours per week on such care, while men averaged three hours per week.

In Canada, the value of care provided by family members and volunteer workers to dependent persons or persons with decreasing independence is estimated at between $5.1 and $5.7 billion annually, according to a study based on 1996 data.[10] That estimate was obtained by multiplying the number of hours Canadians spent in providing care to persons aged 65 or older who needed long-term care, by a weighted average of market wages for the work done. (Data on the number of hours spent providing care were taken from Statistics Canada's 1996 *General Social Survey* on time use. The rates of pay were established by Statistics Canada.) In other words, this unpaid work is estimated to represent the equivalent of almost 276,000 full-time jobs.

Six years later, in light of salary increases and the aging of the population, the value of care provided by informal caregivers and volunteers to the same group of elderly people is now probably closer to $6 billion. Moreover, it is important to note that approximately a third of the persons receiving home care are under 65 years of age.

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(8) Canadian Home Care Human Resources Study, *Setting the Stage: What Shapes the Home Care Labour Market*? Phase 1 Highlights, 4 December 2001 (http://www.etudesoinsdomicile.ca.)

(9) Janet E. Fast and Judith A. Frederick, "Informal Caregiving: Is it Really Cheaper?" document presented to the International Association of Time Use Researchers Conference, Colchester (U.K.), 6-8 October 1999.

(10) *Ibid*.

B. Costs for Employees

According to a Statistics Canada study published in 1990, 70.5% of men and 46.8% of women who provide care also have a full-time job.(11) Evidently, when the obligation to provide care interferes with the care provider's employment, for instance in the case of parents with young children, the care provider may incur economic costs. Employment-related costs include the following:

- current and future loss of income because of the need to leave work;
- income lost because of reduced hours of work;
- unplanned leave;
- lateness;
- short days;
- long breaks to provide services to the care recipient.

In certain cases, the reduced number of hours of paid work or the caregiver's withdrawal from the workforce may also entail the loss of job-related benefits such as fringe benefits (health insurance, dental and disability insurance), including retirement benefits funded by employers (registered pension plans or RPPs) and contributions to the Canada Pension Plan (CPP) or the Quebec Pension Plan (QPP). Finally, caregivers may lose future income when their caregiving responsibilities prevent them from taking advantage of professional development opportunities, such as additional training, attending conferences, taking part in new projects and accepting promotions, which often lead to salary increases.(12)

C. Costs and Expenses for Informal Caregivers

Informal caregivers often incur additional expenses in providing care to beneficiaries. They may purchase medical supplies, drugs, equipment and other items. When

(11) N. Keating, J. Fast, J. Frederick, K. Cranswick and C. Perrier, *Elder Care in Canada: Context, Content and Consequences*, Statistics Canada, Ottawa, 1999.

(12) Janet Fast *et al.*, *Economic Impact of Health, Income Security and Labour Policies on Informal Caregivers of Frail Seniors,* study undertaken for Status of Women Canada, Ottawa, March 2001.

the beneficiary and the informal caregiver live in the latter's home, costs related to heating, food, laundry and transportation may increase. Informal caregivers may also bear costs related to services for the elderly, such as the cost of respite care or home adaptation to make living space more accessible. Finally, informal caregivers may "purchase services" such as babysitting services, domestic help and help with exterior maintenance in order to give more of their time to the care recipient.

D. Costs for Businesses, Governments and Society

The provision of home care by unpaid persons affects more than employees' financial situations. According to a study by Watson Wyatt(13) done in 2000, absenteeism is increasingly affecting businesses' financial performance. The study found that direct costs related to absenteeism in businesses had risen since 1997 and were estimated at 7.1% of business payrolls. The indirect costs of absenteeism (overtime and replacement workers) were estimated at 6.2% of business payrolls. Key factors in this cost escalation included the repeated use of sick leave and personal or family leave. Part of these costs is undoubtedly related to providing care for children, the elderly or dependent persons (persons with a physical disability, a chronic illness, or in need of post-hospital care).

The unpaid work done by informal caregivers may also generate costs for governments and society in general. In some cases, a person's withdrawal from the workforce to take care of someone with decreasing independence means a current and future decrease in the State's tax revenue. In addition, the fact that a person leaves paid employment to provide care also means that he/she will be much more likely to depend, in turn, on public income security programs. Indeed, to the extent that the person will have contributed for a shorter period of time to a public or private pension plan, he/she will be less well prepared financially for retirement.

Finally, according to the work specialization theory, a society should allocate appropriate resources to the provision of home care services rather than leaving this activity to informal caregivers who are not necessarily available, well-equipped, inclined or trained to provide the care needed by the recipient. Moreover, society may suffer because of the withdrawal from, or reduction in, professional activity by informal caregivers. In short, it is far from certain that

(13) Watson Wyatt, *Work Canada Survey, Canada 2000-2001*, Toronto, September 2000.

dependence on informal caregivers as the principal source of home care for dependent persons, or those with decreasing independence, is the best use of citizens' skills for the benefit of society as a whole.

FEDERAL TAX MEASURES IN SUPPORT OF HOME CARE

Federal and provincial governments recognize the essential contribution of care provided by informal caregivers to persons with decreasing independence, disabled persons or persons with a chronic illness. However, existing tax measures often provide very limited economic advantages to the informal care providers. Moreover, such measures are often mutually exclusive, so that entitlement to one source of tax relief eliminates entitlement to another, which limits financial assistance.

A. Tax Measures for Individuals With One or Several Dependants

At the federal level, the *caregiver amount* is a non-refundable tax credit designed expressly to provide financial assistance to volunteer caregivers. In 2002, this tax credit could reduce income tax by a maximum of $3,605.[14] Although this is a modest amount in light of the costs incurred by the majority of informal caregivers, it is nevertheless much more than the credit granted in previous years.

The caregiver must live with the care recipient in order to be entitled to this tax credit. Entitlement is also subject to strict criteria concerning kinship, age and the beneficiary's income. Thus, in 2002,[15] volunteer care providers who provided care to a dependant whose income was less than $12,312 obtained the maximum tax credit. Those who provided care to a dependant whose income was between $12,312 and $15,917 received a proportionally reduced benefit.

(14) Canada Customs and Revenue Agency, Form TD1, "2002 Personal Tax Credits Return" (from the Agency web site).

(15) *Ibid.*

The *spouse or common-law partner amount* may also be claimed if the care recipient's net income is less than $7,131 (for 2002).[16] The maximum credit is $6,482 (for 2002).

The *amount for an eligible dependant* may be claimed by a volunteer caregiver who cohabits with a person who is either:

- a parent or grandparent, by blood or marriage, common-law relationship or adoption (legal or de facto);
- a child, grandchild, brother or sister, by blood, marriage, common-law relationship or adoption (legal or de facto), *and* who is either less than 18 years of age, or has a mental or physical disability.

In 2002, the maximum credit was $6,482. It is impossible to claim both the amount for an eligible dependant and the spouse or common-law partner amount.

A care provider may also claim the *amount for infirm dependants age 18 or older.* Unlike the tax credit for informal caregivers, cohabitation is not required. However, the annual net income of the care recipient must be less than $5,115.[17] In 2002, the maximum credit granted for adult dependants with a disability was $3,605. Caregivers of persons whose income was between $5,115 and $8,720 received a proportionally reduced credit. This credit cannot be claimed at the same time as the *caregiver amount*.

B. Tax Measures for Individuals With Decreasing Independence or With a Disability

The federal tax system provides other tax breaks directly or indirectly related to decreasing independence for care recipients such as persons with a disability or those who have high medical expenses, including many persons receiving home care from a volunteer caregiver. The application of unused amounts of the care recipient's federal tax credits to the caregiver's tax return may offset some of the various costs and expenses incurred by volunteer caregivers.

The tax reductions in question are the following:

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(16) *Ibid.*

(17) *Ibid.*

- the medical expense tax credit;
- the disability tax credit;
- the attendant care expenses deduction.

1. The Medical Expense Tax Credit

This tax credit applies to taxpayers who incurred large medical expenses for themselves or for a dependant. Eligible medical expenses[18] are amounts paid to a health professional to obtain medical or dental services, the cost of prescription drugs, equipment or supplies, amounts paid to a full-time health care attendant, payments for full-time care in a care facility or nursing home, etc. They may also include rental expenses or other expenses related to devices and accessories. Under certain conditions, private health insurance premiums may be eligible. If the medical treatment needed is not offered locally, the cost of travel necessary to receive the treatment elsewhere may be considered an eligible expense.

Reasonable home renovation or adaptation expenses may also be deducted as medical expenses (up to a maximum of $2,000), if these expenses allow the person to have access to the home or to be mobile or functional within it.

The medical expense tax credit reflects eligible expenses that have actually been incurred. It takes into consideration the taxpayer's income and the care recipient's income. The deductible portion of eligible medical expenses claimed is the portion of those expenses that exceeds the lesser of the two following amounts: a fixed amount ($1,678 for 2001; this amount increases yearly, whenever there is an increase in the annual consumer price index), or 3% of the taxpayer's net income for the year.

2. The Disability Tax Credit[19]

This credit applies to individuals who have a "severe and prolonged mental or physical impairment" or to individuals who support a dependant with such an impairment. The base amount for persons with a disability is a non-refundable tax credit that reduces the tax to be

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(18) Canada Customs and Revenue Agency, *Medical Expense and Disability Tax Credits and Attendant Care Expense Deduction,* Interpretation Bulletin IT-519 (from the Agency's web site).

(19) *Ibid.*

paid by the taxpayer. In 2001, the amount for disabled persons was 17% of $6,000, or $1,020. Any unused portion of the individual's disability tax credit may be transferred to the individual's spouse or to a "supporting individual." Certain eligibility conditions apply.

3. The Attendant Care Expenses Deduction[20]

This deduction is granted to individuals who have incurred expenditures to obtain necessary personal care that allows them to work. Expenses incurred to hire a health care attendant may be deducted as attendant care expenses, or claimed under the medical expense tax credit. If they are claimed as a deduction, all of the following conditions must apply:

- the person claiming the deduction must be entitled to the disability tax credit;
- the payments made were for care dispensed in Canada in order to allow the person to earn an income;
- the health care attendant was not the spouse of the person with the disability;
- the health care attendant was at least 18 years of age when the payments were made;
- no one has claimed the attendant care expenses deduction as a medical expense tax credit.

The allowable deduction for attendant care expenses is limited to two-thirds of earned income.

THE PAY AND WORKING CONDITIONS OF HOME CARE PROVIDERS

Canada's Association for the Fifty-Plus (CARP) highlighted human resources as the major issue in the home care sector in its 2001 annual report on home care in Canada.[21] Insufficient remuneration, mediocre working conditions and severe difficulties related to personnel recruitment and retention generally seem to characterize the home care sector in Canada. In a field where human relations are crucially important, such a situation merits greater attention, given its possible impact on the quality of services provided to a vulnerable clientele.

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(20) Canada Customs and Revenue Agency, Form T929, "Attendant Care Expenses" (from the Agency's web site).

(21) Karen Parent *et al.*, "Home Care by Default, Not by Design," *CARP's Report Card on Home Care in Canada 2001*.

A. Pay and Benefits

The partial data available on pay in the home care sector show that in some provinces, salaries are lower than those paid in hospitals and long-term care institutions for equivalent positions. Aside from being paid less, home care providers may also have to face less job security, less regular hours and a less stable work environment.

Working conditions seem particularly difficult for home support workers (visiting homemakers and social services assistants), since pay is often close to the minimum wage and fringe benefits are often limited, especially for non-unionized employees.

Several factors contribute to the difficult working conditions of visiting homemakers and social services assistants, in particular:

- strong competition and the fragmentation of the industry into many small for-profit and not-for-profit businesses;
- the low rate of unionization as compared to other workers in the health and social services fields;
- the large number of unpaid informal caregivers and volunteer workers, which tends to depreciate the monetary value attributed to work in this field;
- the clientele's limited capacity or unwillingness to pay;
- employers' insufficient understanding of the skills needed to perform these tasks.

In many cases, home care sector employees can be recruited on a casual basis or for a short term, a measure that allows the employer to save by eliminating the obligation to provide fringe benefits.(22) In rural areas, certain workers are not compensated for the time they spend travelling between clients. Many part-time workers have more than one job to allow them to make an adequate income. Such employment situations have repercussions both in the short and long term on the employees, and they are more vulnerable to the risk of injury and exhaustion.

(22) Canadian Home Care Human Resources Study, *Setting the Stage: What Shapes the Home Care Labour Market?,* Phase 1 Report, Ottawa, February 2002.

B. Increasing Complexity and Volume of Home Care Providers' Work

The shift to ambulatory care and a more marked tendency toward "hospitalization at home" in several provinces have meant that the provision of home care is becoming increasingly complex and necessitates more advanced training. On the one hand, the tendency to reduce hospitalization means that home care providers must deal with sicker clients who require more care. Simultaneously, the increased use of more advanced devices and technology and a more complex pharmacology have made it possible to provide a broader range of health care services at home, whether on a short- or long-term basis.

Thus, home care workers must have more specialized and more diversified skills and medical knowledge than they did before to perform their work properly. This situation should generally lead to better salaries, barring which the shortage of workers and the deterioration in the quantity and quality of services will worsen.

C. Personnel Recruitment and Retention

The home care sector suffers from a shortage of qualified workers, especially in rural areas. Aside from the difficulty of attracting competent workers, the high rate of departures is a significant problem which the sector must resolve. The high level of absenteeism is another challenge.(23)

Because of the lack of a stable work environment, many workers abandon the sector and many find little motivation to accomplish quality work. The mediocre working conditions thus directly jeopardize the provision of home care.

D. Training

The increased complexity of home care points to the need for continuous training for visiting homemakers and social services assistants. As in other sectors of economic activity, proper and continuous training of human resources is essential to working effectively with the clientele when available resources are barely sufficient to meet the demand.

Currently, the scarcity of human and financial resources, the schedules, the isolation of the workers and the fragmentation of the work among many home care businesses

(23) Parent *et al.* (2001).

complicate the implementation of continuous training programs to allow visiting homemakers to keep abreast of standards of practice, developments in research and technology, etc. This problem also affects other workers who provide home care, as well as informal caregivers.

A high turnover rate also means that visiting homemakers and social services assistants are not always as experienced as those they replace. This continuous loss of expertise further weakens the home care sector and the capacity of the businesses and organizations that provide such services.

THE DEMOGRAPHY OF INFORMAL CAREGIVERS AND THE PROFESSIONALIZATION OF HOME CARE

Currently, the majority of informal caregivers are women helping members of their families, who must often simultaneously manage responsibility for elderly parents and their own children (making them members of the "sandwich generation") while holding down a full-time job. In addition, women aged between 60 and 70 are often grappling with the needs of very elderly parents at the same time as they must face the adjustments required by their own retirement or that of their husband, and a greater likelihood of experiencing health problems.

However, the drop in the birth rate, the increased participation of women in the workforce, the increase in the divorce rate and in single-parent families, and the geographic dispersion of families are factors that limit, and will continue to limit, the capacity of families to shoulder greater responsibility for home care.

To these must be added the fact that informal caregivers often do not have the necessary capacity (physical, mental and financial) nor the necessary expertise to provide the care needed by the person with decreasing independence or a disability.

Given the demography of informal caregivers and the significant problems facing the home care sector, there might be advantages in moving towards greater professionalization – in particular for visiting homemakers and social services assistants – in providing care for persons with decreasing independence. This approach would certainly require additional funding, but it would help to ensure that Canadians receive the care they need from competent personnel.

PREPARING FOR THE FUTURE

A. Encouraging Foresight

The majority of Canadians today seem to underestimate the risk of decreasing independence. This myopia, voluntary or not, is probably due to the fact that people cannot see the relevance of setting funds aside to *insure* themselves against a risk which, to their minds, might arise only in 30, 40 or 50 years, whereas they must deal with more immediate financial needs in the short term.

Some people also seem to think that the State will ensure their well-being should they lose their independence. They overestimate the coverage actually provided by provincial long-term care programs, to which they probably believe they are unconditionally entitled. In fact, because of limited resources, most provincial home care programs offer benefits that vary according to the financial resources of clients, service quotas or waiting lists. All or practically all of the public provincial home care networks give priority to the neediest clients in allocating their resources, while the better-off contribute to costs according to their means and level of family support. On the human level, this policy is justifiable. However, one may wonder whether it does not involuntarily encourage people not to put money aside and not to provide for the future. By the same token, the Canadian tax system, through its tax credits, provides most of its assistance to individuals with very modest incomes.

In light of the expected increase in demand due to the aging of baby-boomers and the relative decrease in the number of informal caregivers, some people may be subject to rationing of services from the public network without necessarily having sufficient financial resources to find alternate solutions.

The likelihood of rationing is leading an increasing number of people to seek solutions outside the public sector. Unless the funding for public home care programs evolves at the same rate as the demand for care, this tendency will increase, along with the aging of the population. Between 1999-2000 and 2000-2001, per capita private expenditures on home care jumped by 18.6%, while provincial government expenditures in the same area increased by only 3.9%.(24)

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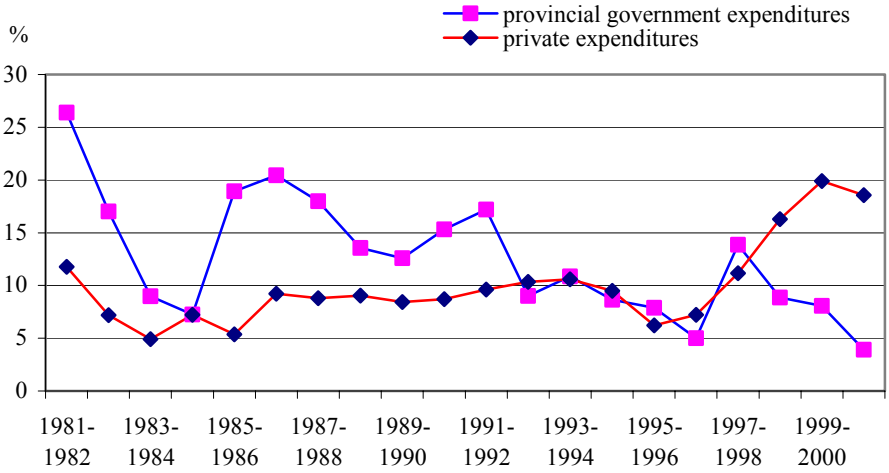
(24) Figures are from the Library of Parliament, Parliamentary Research Branch, based on Health Canada data (2001).

Table 1: Annual Growth of Public and Private Per Capita Home Care Expenditures



Sources: Health Canada, Library of Parliament

Incidentally, beyond the myopia about personal loss of independence, there also seems to be myopia as to the potential role everyone may be called on to play as a care provider (informal caregiver) to members of one's own family, and what this may entail in human and financial terms. In fact, it should be noted that several provinces – in particular, Alberta and British Columbia – state explicitly that the purpose of home care programs is not to *replace*, but to *complement*, the work of informal caregivers.

This type of subtlety is lost on many people. Canadians might behave differently with regard to savings if they had a clearer idea of the risks and consequences of the loss of independence.

Given the Canadian demographic pyramid, it is not too late to begin to make Canadians more aware of the implications of loss of independence, of the particular needs (including financial needs) created by aging, and the costs of home care or institutional care. Governments could bring in new tax measures – as they did with Registered Retirement Savings Plans (RRSPs), and Registered Education Savings Plans (RESPs) for the post-secondary education of children – to encourage people to save to meet the costs of the long-term care they will need.

However, that strategy also has its limits. According to Statistics Canada, only 6.3 million Canadians contributed to an RRSP in 2000, out of an active population of more than

15 million people. Moreover, despite the positive economic climate, the average contribution in 2000 was only $2,700.

Similarly, at the end of 1999, close to 5.3 million workers contributed to a Registered Pension Plan (RPP), i.e., 41% of paid workers in Canada. Despite massive campaigns on the part of financial institutions and governments, which have been going on for years, to urge citizens to save for retirement, a large proportion of Canadians still depend solely on government income security programs (CPP, QPP, Old Age Security, Guaranteed Income Supplement, and Spousal Allowance).

B. Reforming Home Care Funding

In October 2002, the Standing Senate Committee on Social Affairs, Science and Technology tabled its final report on the state of the health care system in Canada.(25) Three important recommendations in the report urged that home care in Canada be strengthened. The first concerned active home care (post-acute home care [PAHC]):

> The PAHC program be treated as an extension of medically necessary coverage already provided under the *Canada Health Act,* and that therefore the full cost of the program should be borne by government.(26)

The second and third recommendations concerned palliative care provided at home:

> The federal government examine the feasibility of allowing Employment Insurance benefits to be provided for a period of six weeks to employed Canadians who choose to take leave to provide palliative care services to a dying relative at home.(27)
>
> The federal government examine the feasibility of expanding the tax measures already available to people providing care to dying family members or to those who purchase such services on their behalf.(28)

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(25) Standing Senate Committee on Social Affairs, Science and Technology, *The Health of Canadians – The Federal Role – Final Report on the State of the Health Care System in Canada*, Ottawa, October 2002, chap. 8 and 9.

(26) *Ibid*., p. 172.

(27) *Ibid*., p. 178.

(28) *Ibid*., pp. 178-179.

According to the Senate committee's estimates, post-acute home care would cost $1.1 billion per year (with funding being provided equally by the federal government and the provinces), and providing Employment Insurance benefits to workers who decide to voluntarily leave their job to provide palliative care to a relative would cost approximately $250 million per year. There is no doubt that these measures would be extremely useful for care recipients and informal caregivers and would offset part of the costs being borne by all of the economic agents. Similar programs already exist in certain countries, including Sweden(29) and Germany.(30)

In its recommendations, the Senate committee no doubt deliberately chose to support acute home care and palliative home care as the first natural step in broadening health care coverage under the *Canada Health Act*. However, even if the Senate committee's recommendations were one day to become reality, Canada's overall policy concerning responsibility for providing care for persons who have a long-term loss of independence – the sector for which approximately two-thirds(31) of home care is being provided – should nevertheless be reformed, given the expected decrease in the number of informal caregivers. In this regard, government might consider the creation of a financial or tax framework that would give all citizens access to the social safety net. The framework could also offer adequate working conditions to home care workers in order to ensure the stability and development of the care supply.

In this regard, certain countries such as Germany or France have already put in place complex, though very different, universal systems to ensure that access to adequate services does not randomly depend on the capacity or availability of relatives or the ability to pay. In relation to proposals for the use of the Employment Insurance fund, the notion of an Old Age Insurance Fund raised in Quebec's Clair Commission report could perhaps be revived; but this time, it might go beyond the simple statement that this would be a new tax, which can easily be dismissed. As has been demonstrated above, the absence of a tax or other mechanism ensuring adequate funding for home care does not mean that taxpayers, businesses and society are not footing the bill.

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(29) M.-E. Joël, "Notes on Social Protection in Sweden," in *The Dependency of Elderly People: Synthesis and Perspectives*, report of the task force chaired by J.-P. Delalande and M.-T. Join-Lambert, Haut Conseil de la Population et de la Famille (High Council on Population and the Family), Paris, 1999.

(30) Rudolf J. Vollmer, "Long-Term Care Insurance in Germany," address presented at the European Seminar on Dependency, Porto, 12 May 2000.

(31) Health Canada (1999).