# ELDER CARE POLICY ISSUES IN CANADA:

# A LITERATURE REVIEW

by

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# 1 Introduction

The Canadian single-payer health care system is intended to ease the financial and familial stresses of seeking health care for all Canadians. Government budgets and provisions for elder care are not currently adapting to the growing elder[1] population and the anticipated stresses on the health care system that will result from an influx of elders. Scholars estimate that virtually all the OECD countries will experience an escalation in costs of long-term care for elders that will compromise the financial stability of individual (elder and caregiver) and social finances.[2] Current health care policies will be crucial in managing these coming costs. Predictions also suggest that, since seniors will live longer in the future with chronic conditions like arthritis/rheumatism and high blood pressure that require attention and battling cancer and heart disease which are the main cause of death for seniors in Canada[3], they will require more formal and informal health care. The current system will experience supply shortages. The demand for formal and informal care services is already showing these symptoms. This is demonstrated by the increasing wait times for acute care and nursing home beds as well as increasing waiting for other procedures/surgeries in hospital because elders are waiting for long-term care (LTC) transfers are placed in beds that are meant for recoveries. This pressure will require immediate government intervention to prevent extensive health care consequences that can also affect the economy and efficiency of government funds.

Statistics Canada estimated in their 2002 General Social Survey that nearly half of all seniors receive care solely in an informal setting, i.e. care given by family and friends.

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[1] Over 65 years old.
[2] de Castries (2009).
[3] Cranswick (2002).

This is indicative of a growing trend away from the formal and 'institutionalized' form of care. The report also found that there was a noticeable substitution away from informal to formal care past the age of 75.[4] A later report on aging by Statistics Canada estimated that in 2007, one in five Canadians aged 45+ provided care to seniors.[5] Support for these caregivers is not given by the government. The government needs to take a more active role in creating policies to support caregivers because there is growing concern for health care budgets not being sustainable. CBC news reported in 2004 that Canada has been increasing it health care budgets as a percentage of Gross Domestic Product (GDP). Seven percent of GDP was allocated to health care spending in 1975. This number grew to ten percent in 2003. Experts like Joe D'Cruz say this is 'a very significant change over a fairly long period of time'.[6] In fact, from 1975-1991, health care spending for Canada has grown 3.8% per year and between 1996 and 2001, 5.4% per year.[7] The increasing costs of health care due in part to the ageing population cannot simply continue to grow and account for more GDP and government budgets. Government revenue cannot be continually directed towards health care budgets without the country feeling negative effects. If the budget allocations to health care grow more than government revenue, health care spending cannot be sustainable.[8]

With the recent economic downturn, government budgets are already being curtailed and constricted. The trend in current data indicates that without a government plan for managing health care costs and using other policies to address the growing financial drain more creatively, government budgets will not be able to allocate money

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[4] Cranswick (2002).
[5] Cranswick (2008).
[6] "Price of Care" (2004).
[7] "Price of Care" (2004).
[8] "Price of Care" (2004).

fast enough to keep up with the predicted surge in the demand for elder care in the future. Statistics Canada predicts that by 2036, the senior population will have grown almost 10% (from the base year 2011) and will continue to grow. Elders will account for 23.6% of the Canadian population past 2036.[9] Since the number of eldest seniors is also growing (90+ will have grown by 1.8%) by 2036, the costs of taking care of these elders will also increase for health care need increases with age. Expensive solutions might be to build new facilities, hire and train more professional elder care staff but this will require government money that is far outside the current federal and provincial health care budgets. This is not the most efficient solution for Canadian and provincial governments. Instead, it is advisable for governments to use labour force policies, tax credits, insurance markets and pension policies to ease debt and develop more efficient elder care system. This paper will examine the economic impact of elder care in the informal and formal care sector of the Canadian health care system and examine current Canadian policies while discussing other policy options used in the European elder care system.

The analyses are limited in empirical scope due to the unavailability of health care data, especially in studying elder care. It is difficult for government to base policies on theory alone so the last section of this paper will provide some recommendations for collecting more accurate and useful data to help modify and amend future elder care policies. Another barrier to effective policies that will be discussed is the lack of consistency across provinces. Federal and provincial governments must make policies that will complement each other's health care systems and responsibilities given that health care systems are under provincial jurisdiction and health care budgeting and policy options discussed in this paper will fall under federal authority. This is difficult in the

[9] Statistics Canada (No date). Percentages based on author's calculations from Statistics Canada data.

current system, however, since definitions for many types of care are different in each province.

# 2 Elder Care

## 2.0 The Issue

European projections of total health care expenditure as a percentage of country Gross Domestic Product (GDP) are expected to rise in the coming years and Canadian expectations are no different. The Organisation for Economic Co-operation and Development (OECD) Health Data in 2011 reported that spending on health care is increasing more rapidly than economic growth in OECD countries. They report that in 2009, health spending has rose from a 2008 level of 8.8% to 9.5% in 2009.[10] This increase will continue for Canada, an OECD country, and will require more subsidies and public expenditure to care for the growing senior population. The World Health Organisation (WHO) expects that by the year 2050, 30% of the European Union population will be over 65 years of age.[11] Policies will have to be created and changed in order to ease the financial strain and bridge the gaps in the health care system. To achieve this aim, the government must use all health care systems at its disposal before spending on new infrastructure. By increasing caregiver support so that elders are cared for at home *first* for the maximum amount of time before being admitted to formal care institutions, and fixing the currently underused private long-term care insurance to reduce the financial burden of elder care on elders and their family, the government will help ease financial and sustainability issues in the health care system so that government is not having an unmanageable explosion in health care debt and hospital waiting times .

[10] OECD (2011).
[11] Tarricone and Tsouros (2008).

To address the wait times in another way, Canada currently has a severe throughput problem. The increasing admittance of seniors to hospital beds and acute care units adds to the congestion in hospitals that are already operating at over limit. Government reports like the Romanow Commission (2002) have already stressed the importance of decreasing waiting times and the right to timely health care. This issue is in part due to the large number of seniors who are waiting in hospital beds for transfers to long-term care institutions (i.e. nursing homes, continuing care facilities etc.) and preventing the entrance of the rest of the Canadian population to hospitals for procedures needing these beds. The solution to decreasing waiting times does not lie with increasing budgets, limited financial resources for health care means that the viable alternative must be to keep seniors at home as long as possible and provide alternate accommodation options while they are waiting so that the hospital beds are used by the individuals they are actually intended for. In order to manage this, the government must make staying at home a viable alternative – financially and socially. To do this, alternatives such as universal long-term care insurance and caregiver support schemes like labour force programs, and pension and tax credits will be beneficial.

In addition to the shortages of resources and funds directly in the health care system, there is an employment issue that may jeopardize the stability and productivity of the labour force. Women, for example, are more likely to care for seniors and are often already employed in a paying job.[12] Giving support to a senior family member will likely result in these women exiting the work force because it becomes too stressful to manage both. It is estimated that in Ontario alone, 1.4 million women in their most economically productive stage of their life, 25-44 years old, will be supplying care to an elder in

[12] Johnson and Sasso (2006).

2011.[13] If caregiving is forcing these women out of the workforce to care, there will be a domino effect on the economy that will result in a lag in economic production as skills and talents leak out of the workforce and businesses are forced to hire and train new employees. In addition, there will be lost tax revenue for the government and lost household income that can alter consumer behaviour. This is compounded with the losses that are predicted to occur when the baby boomer generation retires and accounts for roughly a quarter of Canada's population by 2036.[14]

In 2009, a Senate Report from the Government of Canada was issued that had an entire chapter devoted to the need for supporting caregivers. Janice Keffe from the Nova Scotia Centre on Aging provided a basic overview of the type of support these caregivers need from the government including respite services, direct payment allowances (compensation and reimbursement), a labour policy that goes further than the current Employment Insurance's (EI) Compassionate Care Leave, and indirect compensation such as tax credits and pension credits to alleviate the financial pressures of caring for an elder person. This will also encourage informal care and therefore decrease government's future elder care expenses.

As part of this Report, the Senators reviewed National Programs in countries like Australia, Germany, the Netherlands, Sweden, and the United Kingdom for policies that might be useful to implement in Canada. The Australian respite program gives advice and aid to caregivers who are untrained and often unprepared to care for their senior family members and friends. The universal Long-Term Care (LTC) insurance coverage in

[13] Zukewich (2003).
[14] Dentinger and Clarkberg (2002), Cranswick and Dosman (2008), Statistics Canada (No date).

Germany is also referenced in the report and is an option for managing costs of elder care for individuals and government.

## 2.1 Data Considerations

Canadian elder care data is an important topic to be brought to the government's attention before any policies are put in place. This paper includes Canadian predictions and data, where available, but most statistics found on elder care comes from European countries or international organizations like the WHO. Lack of Canadian data therefore renders this paper more theoretical in scope than analytical.

Current Canadian predictions of elder populations in the future must be updated frequently as models and populations change. The percentage of the elder population that will be affected with certain conditions such as dementia, cancer and heart disease should also be re-evaluated frequently. If governments do not have access to accurate statistics for elder care that include wait times for long-term care across Canada, predictions of costs for care in each province, employment and unemployment data for caregivers, and hospital bed information that separates the patients who are there for surgery and the patients who are seniors waiting for someone to take care of them.

The government must have complete information on the current situation of elder care in order to make effective new policies that will remedy the problems discussed in this paper. If the federal government were to require provinces to collect acute care, population and waiting time data to start, there is a possibility that policies can be designed specifically to suit Canada's major elder care problems.

The federal government also faces the difficulty of compelling provinces to take on the responsibility of elder care; not simply to provide data and national definitions, but

to follow national standards of elder care as well. Aside from presenting the provinces with the same arguments made in this paper regarding budgets, increased wait times and the possibility of an elder care crisis, the government may wish to explore using conditional transfers like the Canadian Health Transfer (CHT) to solve the provincial issue.

# 3 Role of Government

## 3.0 Introduction

When dealing with the rising economic costs and pressures on the long-term care system, Canada must be aware of the successful and unsuccessful policies that other countries have tried in order to formulate domestic elder care policy. The country case studies used for illustration purposes in this paper provide policy options for Canada to consider. We will discuss which international aging strategies and policies will be most appropriate for and acceptable to Canadians.

Government must also understand the behavioural effects of policies so we examine the substitutability of formal and informal care and discuss how policy makers should approach budget allocation and legislation using this knowledge. The aim of policy makers should be to maximize the use of informal care to prevent premature institutionalization and use of formal care. To achieve an efficient and sustainable outcome, the government will need to understand the nature of caregiving and its tools for incentives.

## 3.1 Elder Care in Canada

In 2000-01, seniors 65+ were the recipients of 43% of all health care expenditures by the government while they only accounted for 12.5% of the Canadian population.[15] If the by Statistics Canada are at all accurate, by 2056, 27% of the population will be over 65+ and 10% will be over 80 years of age.[16] These seniors, most notably those over 80, will require more care and cost the government more in formal care expenses. This

[15] Health Canada (2001).
[16] Statistics Canada (2007).

means that policy must be able to make public health care funds more effective in its distribution of limited resources. The issue of an ageing population is going to adversely impact public finances by requiring more allocation of resources to a demographic that is already being allocated the highest percentage of public health expenditures. This cannot be sustainable in the future and so, the role of government is to develop more fundamental policies that will take a 'bottom-up' approach to maximize the health care system without further depleting an already exhausted budget. In this way, the Canadian government will prevent a health care crisis.

Since health declines with age, caring for a senior between the ages of 65+ is significantly more expensive than caring for any age. The government cannot continue paying in the current system for the growing number of seniors waiting in hospital beds to be transferred to long-term care institutions. Financially, it is more efficient and sustainable to enact policies that will enable hospitals to reduce the surgery wait times (which are a constant issue in Canada, see Romanow Report (2002)) and free more beds for short term hospital visits recovery rather than a holding area for seniors who might wait over three months for a nursing home room.[17]

In 2000-01, Health Canada estimated that 78.1% of total home care expenditures in that time period were funded by the public sector. 73.9% of these expenditures were for seniors 65+ to pay for home care.[18] A major motivation for government intervention in the elder care institution is the growing concern that, while Canadians might be saving for their retirement, there is a failure to factor in the costs of long-term care. These costs include in home professional help with daily tasks or institutional expenses due.

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[17] Capital Health employee (2011).
[18] Health Canada (2001).

Lack of saving might be due to myopic nature. That is, individuals do not have the foresight to see that they might require expensive long-term health care in the future. The LTC insurance market is comparable to the flood insurance market; individuals have a lower perceived risk of needing to claim.[19] People may misjudge the risk of needing long-term care. Their real risk of requiring nursing home care (in the United States) is actually 43% for individuals over 65.[20] To solve this myopic attitude, the authors Zhou-Richter, Browne and Gründl (2010) conducted analyses to test if more information on nursing home costs and likelihood of requiring long-term care will impact the demand of LTC insurance. They found that if a subject was provided with more information about the risk of needing LTC, they are more likely to purchase LTC insurance.

Even if individuals *do* factor the cost of LTC care into their savings, since health care costs are rising faster than income, any amount saved will be too little by the time they require these funds.[21] It is estimated that 6% of individuals, according to a survey conducted by ICM for the housing and care charity 'Anchor', were saving for their own care in retirement.[22] If this lack of saving continues, government will be paying more than it can afford in elder care costs.

Statistics Canada has reported that over the last eight years personal private expenditure on medical care and health services has been increasing.[23] In 2008, America's Health Insurance Plans (AHIP) estimated that the cost for one year in a nursing home is $75 000 USD.[24] This, however, is an average figure; nursing homes can

[19] Zhou-Richter, Browne and Gründl (2010).
[20] Cremer, De Donder and Pestieau (2009).
[21] Martins and de la Maisonneuve (2006).
[22] Brindle and Clark (2011).
[23] Statistics Canada (2011).
[24] de Castries (2009).

be much more expensive to the average consumer - especially with costs for long-term care facilities on the rise in the face of static financial aid. In Canada, there are government subsidies that pay for institutional expenses in the event financial assessments deem individuals unable to afford the cost. This means that eventually, the exploding costs of health care will drain individual assets first and then will be paid for by an already strained health care budget (that does not seem to be saving either).

One role of government in Canada is to explore the possibility of universal LTC insurance and why the private insurance market for LTC is persistently underused. There are several reasons why this is the case. Many theories suggest that the under-use of LTC insurance when provided in private markets is because people are either unaware it exists or are not forward thinking individuals to foresee requiring LTC in their old age. In the article by Zhou-Richter, Browne and Gründl (2010) they suggest that if a government undertakes extensive informational campaigns that publicize the costs of nursing home care, this will increase the demand for LTC insurance. Cremer, De Donder and Pestieau (2009) also discuss the possibility that a truly altruistic parent will see that if they ever need LTC they would be a financial burden on their children. This will serve to motivate them to purchase LTC insurance to ensure that they will be cared for without needing familial aid. For example, they cite a French study that found 'being married and having children make it likelier to purchase private LTC insurance' which enforces the idea that having a family serves is an incentive for saving for care in retirement. There are also options for the government to use 'nudge' policies that might include 'auto-enrolment' into a certain policy program, in this case, this could be LTC insurance.[25]

[25] "A special report on pensions - A nudge and a wink: how to persuade employees to provide for their old age" (2011).

Other possible reasons why LTC insurance is not considered part of retirement planning is outlined by Cremer, De Donder and Pestieau (2009) in their paper about sustainable LTC. They write that LTC insurance may be 'crowded out' by social assistance programs. If people know that there is a social safety net that will cover all their expenses if they are unable to pay for their own care, they are less likely to take measures to protect their own finances – especially if, as previously discussed, they are myopic and perceive their likelihood of needing LTC to be low. Perhaps the most straightforward reason for not accessing LTC insurance is the cost of purchasing the insurance. Over 90% of individuals who do not have LTC insurance find the premiums too expensive to justify the purchase.

The major issue for Canada in the context of LTC insurance in the private insurance market is not that individuals are not purchasing policies. It is that if they do purchase insurance, the private market is likely to fail. Growing need due to an ageing population would place immense pressure on insurance markets and the system would be overwhelmed with the uncertainty of length of LTC payouts or how many people will end up claiming their LTC insurance.

Even though LTC insurance has been generally left to private markets in countries, many scholars, including Cremer et al. argue that private insurance markets are ill-equipped to handle the kind of financial risk involved with LTC insurance.[26] Cremer, De Donder and Pestieau (2009) see three main complications that prevent LTC from being insurable in a private market.

First, the 'risk of escalating costs' makes insuring difficult because costs are already rising faster than GDP which means that pricing LTC is unpredictable. This is

[26] Cremer, De Donder and Pestieau (2009) and Schut (2010).

especially true with the added uncertainty of how long an individual will require LTC. Increasing life expectancy also means that seniors will be living with chronic conditions and disabilities that will require some form of care that will be paid for longer by insurance companies.

Second, since LTC insurance markets operate like any other standard insurance market there is the case of adverse selection and finally there is the problem of moral hazard. In adverse selection, individuals who seek LTC insurance are at a higher risk of needing LTC in their old age. Moral hazard, on the other hand, is an issue because society now sees LTC as the first option when they grow old and lose their own autonomy, rather than 'burdening' their children. The authors are describing an overuse of LTC due to an overestimated need and 'risk' of an elder or a family member losing autonomy. Moral hazard, here, results in over-use and a surge in claims for insurance which will contribute to the insurance market being increasingly unsustainable.

The recently published British Dilnot Commission Report (2011) specifically addresses the insurance market issue and a viable solution. Dilnot illustrated that 'the uncertainty decades down the line on what the costs of our care might be was "too great" for an insurance market to work.'[27] The core of his argument and motivations for his report enforces our earlier argument that there is no insurance market that can insure the increasing costs of health care so that it will be useful in the coming years. The eventual failure of the private insurance markets to manage costs illustrates the need for the Canadian and/or provincial governments to become involved in order to protect individual and public finances and prevent the private insurance market failure.

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[27] Brindle, Mulholland and Sparrow (2011).

The British proposal of implementing compulsory insurance for elder care is a possible solution for Canada. The Dilnot Report proposes a cap on personal savings for social care in old age – an optimal figure of £35 000 and any expenses above this figure should be paid by the government. Since individuals may not be able to afford their 'personal contributions' for care, Dilnot proposes that 'means-tested support should continue for those of lower means, and the asset threshold for those in residential care beyond which no means-tested help is given should increase from £23 250 to £100 000'.[28] The report recommends that this might be funded by a new tax - thus forcing the young, healthy and productive individual to fund their own future expenses or the redistribution of government budgets. The estimated cost of this compulsory LTC insurance plan is £1.7 billion per year.

The U.K. is not alone in proposing universal LTC insurance. The Netherlands provide public LTC insurance for services like professional in-home care, residential (nursing home care) and other formal care, and later offered 'personal care budgets'[29] that would allow individuals to have access to informal care. This was an effective device for saving public finances by allowing individuals to choose their desired form of care and encourage the informal care sector – which was at that time reported to be the lowest number of informal care hours in Europe (300 hours annually for each caregiver).[30] The Netherlands also created more support, information and respite programs to encourage informal care and the use of personal care budgets – this saw an increase in substituting informal for formal care. Although these personal care budgets cost the Netherlands more in terms of health care allocation, as Drummond and McGuire (2001) observe, 'budgets

[28] Dilnot Commission (2011).
[29] As an alternative to 'in kind' transfers.
[30] Schut (2010).

are arbitrary divisions in how resources are organized' and it should be the net gain guides policy makers' decisions on spending, not immediate financial costs or payoffs. The long-term savings and investment in health care infrastructure is much more important as it contributes to the sustainability of the health care systems and only later, its efficiency.

Another viable option for Canada, as suggested in de Castries's 2009 article, is to offer universal LTC insurance with an opt-out provision. Since it will only be the individuals with an alternative LTC financial plan who will opt-out, he suggests that since the principle is to have all individuals benefit from the policy, not simply the economically able, government subsidies may be used to supplement the lower-income premiums and make LTC insurance less costly. For Canada, this scheme would assist Canada in 'reaching the highest coverage rate and leveraging the largest mutualisation effect'.[31] This kind of policy would be economically beneficial by decreasing public expenditures on health care while protecting individual wealth by insurance. In addition, since some individuals may not claim this insurance, there will be available funds for the government to place in other areas of health care.[32]

The Special Senate Report on Aging (2009) put together by Senator Carstairs and Senator Keon, both of whom are champions of elder care in Canada, cite the Netherlands, Sweden, the United Kingdom and Germany LTC insurance and financial compensation policies. Germany's universal LTC insurance coverage sees 90% of the population subscribes to the public provision of insurance while the remaining 10% opts into private

[31] de Castries (2009).
[32] de Castries (2009).

insurance.[33] Germany's universal LTC insurance works so that if an individual has 'State health insurance', he also has LTC insurance. If the individual has 'private health insurance' he is enrolled in private LTC insurance.[34] In a report by Comas-Herrera et al. (2003) for the European Commission, Employment and Social Affairs DG, their extensive discussion on the German LTC insurance system includes the importance of linking the LTC insurance benefits to inflation and wages. In doing so, the rates of insurance contribution will increase on par with wages and inflation, thus allowing the real purchasing power of the insurance benefits to increase as well. Presently, the German government has not made any changes to insurance benefits since the universal insurance's creation; the authors recommend this to be a needed alteration in Germany's LTC insurance system and should therefore be taken under advisement by the governments in Canada if implementing public LTC insurance.

[33] Comas-Herrera et al. (2003).
[34] Cremer, De Donder and Pestieau (2009).

# 4 Informal and Formal Care

## 4.0 Introduction

Having discussed the role of government in the context of the insurance market, it is also important to address the role of government in the context of family/informal care and why it is important to be involved. We have already established that growing national debt and government health care expenses can be addressed by using private insurance markets but the sustainability of health care can also be improved by encouraging the use of informal care. Addressing the relationship between informal and formal care will allow government to more accurately identify its most effective role in the health care sector. This analysis requires establishing a solid definition of each care system.

Formal care is most accurately described by Bolin, Lindgren and Lundborg (2008) as 'the amount of care supplied by the institutionalized health- and social- care systems.' He defines informal care as 'the amount of care and assistance supplied [voluntarily] by close relatives and neighbours.' By establishing the nature of interaction between the two care 'sectors' legislators can use policies as a tool to shape the health care system, and to maximize social welfare and each dollar spent. Policy makers need to also be aware of how the drivers of informal care are changing its supply and jeopardizing the sustainability of long-term care. It is important that the drivers of informal care are not discouraged with new policies. Family structures are weakening with 'nuclear families' falling by 18% and more than half the population unmarried and nearly half with no children.[35] Smaller, more complicated and fragmented families compounded with declining fertility rates and increased rates of divorce coupled with increased female

[35] Ontario Ministry of Health and Long-term Care (2009).

labour force participation[36] all interact to cause the formal health care system to experience enormous demand pressures.[37] When we consider population dynamics, the declining birth rates means there will be a smaller population receiving child tax credits, etc. from the government but more people needing help to care for elders who need similarly expensive and constant care as that of children.[38] The changing population will also demand less in some budget areas and more in others; this will require a change in budget allocation with possibly more focus on elder care and caregiver support. All of the above changes in Canadian demographic leave fewer adults in the future to care for elder family members at home. The pressures of caring for an elder alone, without financial and physical support from other family members, will also decrease the likelihood of undertaking informal care and lead to early institutionalization of elders.[39]

This section will also address the labour force as a driver of long-term care. The inclusion of women in the labour force places a huge stress on informal care because women are the primary caregivers in society.[40] As a result, primary caregivers must consider the opportunity costs of choosing the length and manner of care while balancing financial and work burdens.

## 4.1 Choosing Care

For individuals, choosing to provide informal care to elders or engaging formal care services is a rational choice that can be examined based on the substitutable nature of the two sectors and individual opportunity costs. Understanding under what

[36] Van Houtven and Norton (2004), Cremer, De Donder and Pestieau (2009), Zhou-Richter, Browne and Gründl (2010).
[37] Comas-Herrera et al. (2003).
[38] Dentinger and Clarkberg (2002).
[39] Cranswick and Dosman (2008) and Zhou-Richter, Browne and Gründl (2010).
[40] Johnson and Sasso (2006), Bracke, Christiaens and Wauterickx (2008) Dentinger and Clarkberg (2002), and Masuy (2009).

circumstances individuals choose to provide voluntary care to elders is important in formulating policies. Establishing these links between formal and informal care will help policy makers to shape the elder care system that will support resource efficiency.

Several studies have found a strong indication that formal care substitutes for informal care based on several different indicators.[41] Empirical evidence is used to support this conjecture. In the study conducted by Van Houtven and Norton (2004), the authors found that their two-year sample data showed that when informal care use increases by 10%, there is a corresponding reduction in nursing home stay (by two nights) and formal home health care usage decreases from 8.3% to 7.43%. This evidence implies that informal care reduces formal care use and that there is a link between the two forms of care that can be expanded upon by government policies.

Another study by Carmichael, Charles and Hulme (2010) illustrates the dependency of caregiving on income based on opportunity cost valuations. The authors motivate their paper with a broad introductory discussion of opportunity costs of an individual caregiver. If an individual participates in the labour market, individual trade-offs are between 'employment participation and willingness to care'. Policy makers should note this means there will be clashes between policies that encourage full-employment and policies that encourage informal caregiving.[42] Studies have shown that as the hours of informal care increases, the number of workable hours decrease. The Carmichael, Charles and Hulme (2010) paper uses British Household Panel Survey data (1991-2005) and multivariate analyses to illustrate exactly how employment status can affect a family member's choice to provide care. Results indicate that there is a

[41] Zhou-Richter, Browne and Gründl (2010) and Van Houtven and Norton (2004).
[42] Carmichael, Charles and Hulme (2010).

significant, negative relationship between employment in the workforce (and wage earnings) and possibility of becoming a caregiver. The results are slightly different depending on if the employed is male or female. The probability of becoming a caregiver 'decreases by a factor of 0.838 for men and 0.844 for women' if they are employed. The study's regression for determining the likelihood of becoming a new carer has significant control variables of age and health problems at the 1% level. These results suggest that the propensity to care increases with age and declining health. The study confirms the current data in the U.K. that illustrates that the majority of carers in the U.K. are 40+ and many have declining health.[43]

Since employment status is an indicator of having a higher income, and thus a high opportunity costs, this will indicate a reluctance to care since foregone salary/wages will be too great compared to giving care. The de Castries (2009) study notes the possibility that this might not always be the case. Some individuals with high income and economic status might have a lower opportunity cost since an individual can *afford* to care for the elder in their own home because a higher income/economic status means more savings or access to finances to pay for the cost of living and care even without earning wages. A higher economic status might indicate an ability to take time due to affluence to care without worrying that it will drain their finances.

Statistical results in Ettner's (1996) paper indicate that opportunity costs appear to be different for males and females. This might be due to different perspectives on caregiver duties. Males have traditionally been the primary earners in a household.

[43] de Castries (2009).

Caregiving roles for males might be analogous to this view as males might see their role as a provider of funds to facilitate care rather than preforming direct caregiving duties.[44]

Females, on the other hand, have traditionally been in the direct caregiver role with children as well as in elder care. This seems to continue to have an impact on their opportunity costs. To illustrate in a different way how opportunity costs are affected by gender, we discuss the propensity for individuals to retire given they are caregivers. This depends on gender and the nature of the relationship between the caregiver and the elder. Dentinger and Clarkberg (2002) studied retirement among caregivers and concluded that spousal care is the most significant relationship that can dictate (early) retirement. They claim that women caring for their spouse are five times more likely to retire than women who do not care for anyone. Men are 50% 'slower to retire' when caring for their wives. This is, as previously noted, possibly because males view their caregiving role to include providing financial stability even in elder care. The study suggests male caregivers are less satisfied with their employment. One could argue this illustrates their desire, yet inability, to retire and care instead of their desire to work in order to avoid caregiving responsibility.[45]

Since time in care increases as the length of an elder's life increases, given that the elder is taken care of initially by their children/spouse (i.e. in the informal care system), the government must maximize this care as much as possible to save the future supply and demand issues for formal care. A longer and heavier burden on a caregiver's time and finances is compounded by the predictions that long term care will rise faster

[44] Dentinger and Clarkberg (2002).
[45] Dentinger and Clarkberg (2002).

than national income.[46] This will lead to family members using health care institutions earlier because it is deemed cheaper for personal finances and opportunity costs. Demand will easily outstrip supply of formal care in this case.

The role of government is to develop policies that can be used to extend the use of informal care longer so that the formal care sector will not experience such an influx to the system. Discussed in the Mason et al. (2007) article is the theory that respite care (that is, relief for caregivers) will prevent informal caregivers from becoming overwhelmed, stressed and ill and seeking health care services for themselves. The article lists several forms of respite care including adult day care services and in-home care/aid that might prevent caregiver burnout. Searching thirty-seven databases for studies on respite for caregivers of elder persons, their analysis suggests that respite services generally increase caregiver satisfaction (some reporting more satisfaction than others) and can strengthen the likelihood of care.

Given the complex nature of substituting formal and informal care and the several different ways males and females, workers and non-workers, evaluate their opportunity costs, policy makers must make necessary changes to the way caregivers are supported in order to maximize the use of both care sectors. By balancing the burden of care between the formal and informal care sector, the government will be able to ensure each system is being used sustainably, most effectively and in the interest of Canadian society and public funds. Creating policies with the knowledge of how potential caregivers value caregiving and the opportunity costs accompanying care will allow the policies to be more effective in controlling social behaviours. The resulting benefits of these policies will be the aforementioned relief on hospital waiting times, shortages of

[46] Cremer, De Donder and Pestieau (2009).

beds and funds, and will contribute to the overall expediency of Canada's health care system. The proper framework for elder care polies must be in place before the bulk of the baby boomer generation seeks elder care resources and funds from a government that cannot keep up with the demand.

Having a policy that has provisions for labour support will allow the government to lower the opportunity costs for each individual, thus encouraging the provision of informal care (i.e. the decision to provide care to their elder), while also relieving the pressures on the formal care sector that would rapidly become unmanageable and too demanding on the health care budget.

Fast, Williamson and Keating (1999) show that there are economic and non-economic costs to informal care that will impact caregivers and the economy on a broader scale. By including valuations of lost employment and wage opportunities, the value of unpaid labour and psychological costs to the caregiver, policy makers can have a more complete prediction of lagged costs of informal caregiving on public finances and overall effects on standard of living, quality of life and social welfare. Fast, Williamson and Keating (1999) point out that policy reform become complex in the informal care issue because several interest groups must be considered as each will be affected differently. Major groups Canada should consider are the elders, caregivers/families and employers of caregivers.

An additional perspective that we can discuss briefly is the view that long-term care is a luxury good rather than a necessity. This theory was presented in Schut's (2010) article. He models the income elasticities of demand for health care and found that they are greater than unity. This implies that substituting formal for informal care is a luxury

that 'may only be publicly affordable if a country as a whole reaches a certain aggregate level' of income. Given this perspective on long-term care, there is still merit in the previous analysis that providing informal and formal care requires individuals to have low opportunity costs. Giving up employment and wages or paying for professional care is a luxury for many families instead of a necessity.

The role of government is to assist care by enabling individuals who wish to provide care. It is in the government's best interest in terms of managing budgets in preparation for explosion of need for elder care. Government can also decrease wait times and hospital congestion. Hospitals are overwhelmed even now by the current number of seniors in acute care that are waiting for long-term care facilities. They are waiting in these beds because there is no one able to care for them at home – either by choice or financial necessity.

The role of government in the formal care sector is to not only review waiting times and ensure seniors are moving through acute care to long-term care facilities quickly and efficiently, but also to work closely with provincial governments to develop standardized definitions of elder care. This will be a huge issue as the government begins to communicate new policies to the provinces (or vice versa) for elder care. A Report of Continuing Care Organization and Terminology was prepared for the federal government in 1998 study by Hollander and Walker that was meant to "propose common vocabulary for describing Continuing Care systems and components across jurisdictions." If the provincial and federal governments do not review their definitions of informal care, continuing care, long-term care and other elder care terminology, policies will be incompatible, or at least difficult to implement and homogenize across provinces.

# 5 Employment Effects

## 5.0 Introduction

The need for supportive programs for caregivers stems from the many hidden costs of informal elder care.[47] The aim of government should be to encourage informal care use with a view to solve current formal care congestion. Individuals are faced, not only with the high cost of informal care, but also with missed employment opportunities in addition to jeopardizing their own health as a result of carer burn-out and possible sicknesses and injuries related to caring for an elder.[48] All of the above issues contribute to an individual's supposition that caring for an elder is too difficult to handle and forces them to place elders in the care of the state.

If individuals do choose to care for elders in a home-based setting, the true economic estimation of this unpaid labour and the likely employment loss is difficult to estimate. Caregiving duties are in the same informal labour market as cooking and cleaning and are characteristically difficult to value. In addition, caregivers who are employed are more likely to take more sick days, have less paid employment hours and are more likely to abandon paid employment. This loss of income to the individual, consequent losses to a company's productivity and the long-term effects on consumer markets are also difficult to value; however, we can discuss the general effects in the context of the labour supply drawing on several studies and country cases while also discussing how choosing to provide informal care is endogenous to the labour supply.[49]

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[47] Fast, Williamson, Keating (1999).
[48] Perhaps even seeking attention earlier in life for chronic conditions than they normally would have if they had lived without the stresses of caring for a senior friend or family member
[49] Carmichael, Charles and Hulme (2010).

## 5.1 Labour Supply

Generally, policy makers view informal care as a less costly alternative to elder care[50]. By viewing informal care as part of the informal sector, the principle of solving the imputed value of the informal sector is comparable to how scholars value housework, or other areas of the informal sector. Although calculating the financial cost to informal caregivers is still ambiguous, several scholars have developed accurate models to suggest economic estimates. According to a 1998 Canadian study, informal care was roughly estimated to be over $80 billion in that year (this amount is based on an opportunity cost method of evaluation). [51] This amount is roughly the size of Canada's manufacturing industry and is continuing to increase. This estimate illustrates the magnitude of the issue policy makers must manage and an idea of how much the informal care sector might account for in lost national income and individual income assuming caregivers quit work to care. The resulting economic costs are the lost personal and gross national income, lower work quality, and high employee turnover.[52]

The concept of providing financial and social assistance for caregivers is a congruous practice in keeping with the socialist health care system that the Saskatchewan government under Premier Tommy Douglas first introduced. Individuals are faced with the difficulties of choosing between employment and unemployment. If they choose the latter, they will experience lost income that can result in the state caring for the elder in the future and if they choose the former, the state will care for the elder in an institution. The optimal solution is that government chooses to create social assistance policies that

[50] Fast, Williamson and Keating (1999).
[51] Ontario Ministry of Health and Long-term Care (2009), Zukewich (2008).
[52] Fast, Williamson and Keating (1999).

will be tailored to suit the specific requirements of caring for an elder rather than having the standard social assistance programs be lacking in these issues. By adopting new assistance policies they might preclude early enrolment in institutions, thereby addressing congestion issues and preventing the government from having to invest in more formal institutions. Lastly, although the government will have to pay for the financial assistance that can ultimately be used to hire formal care workers, the money given will enable informal caregiving to be used along with formal care – this will save money for the government because informal caregiving is a substitute for formal care and with therefore ease the demand pressures on formal care services.

As a starting point for examining the most effective caregiving assistance programs, the government must understand that lack of flexibility and provisions for employees who have become caregivers result in caregivers missing work more often, being late or quitting work to attend to an elder. The country will see a compounded loss of skills from the labour force as the baby boomers retire and caregivers choose earlier retirement or quit their employment to care for an elder. In short, there will be considerable losses in a workforce that is already anticipated to weaken due to ageing. Business production and output will likely be a major casualty with widespread consequences for the Canadian economy. Losses in GDP, shortages in supplies of goods and services accompanied by rising prices will result from the loss of workers and, by extension, the decline in business production and efficiency.[53]

In Drummond and McGuire (2001), the chapter on the role of productivity costs deals largely with employment costs when an individual employee is sick. We can easily draw parallels between an employee that has taken leave from work due to illness and

[53] Ontario Ministry of Health and Long-term Care (2009).

one who has taken leave from work to give care to an elder. The author's analysis is called the 'friction cost approach' and is attributed to several Dutch economists who modeled 'lost time from paid work due to illness'.[54] They believed that the standard neoclassical theory used to value human capital lacked realistic features of the employment market that included both frictional and non-frictional unemployment. It is also necessary to account for the fact that illness (or in this study's case, leave) means that forced unemployment decisions have not been made at the margin. Neoclassical theory assumes that to be the case. Decisions on this extensive margin are an important issue to note because the neoclassical theory of human capital estimates a potential, rather than actual, loss in productivity and is predicated on the assumption that there is no involuntary unemployment. However, in reality, when a person goes on leave there are numerous unemployed individuals to choose from to fill their place. When selecting an employee from the unemployed group, there is a definite loss in productivity due to searching and training costs.

When on leave, the cost approach must account for the cost to the labour force that is far more widespread than simply lost wages for the individual. Given the mainly theoretical analysis of Drummond and McGuire (2001) and the difficulty in estimating the lost wages and the costs of care (since care is very subjective), it is difficult to say whether in our analysis the cost of care far exceeds the forgone wages of caregivers.

Drummond and McGuire (2001) explained that a 1% decrease in working days for an individual corresponded to a 0.8% drop in production. The authors recommend using a full macro-economic model to determine the full chain of effects that 'sick leave' or 'caregiver leave' have on the system. There are resource and productivity losses (and

[54] Note that for the purposes of our analysis, we see the illness in an elder, instead of the employee.

hence national income and international competitiveness losses) that are felt by the company and other employees. Together with the cost of training and hiring a temporary replacement and the "loss of productivity [present] during that 'friction period'", there is a need for government to look at labour policy options.

Some employers are taking a more proactive approach to retain workers even when they are caring for an elder. The Ontario report on Caring-About-Caregivers express concern that there is not enough communication between employers and the government in order to enable the caregiver to balance work and caring without giving up their means of support and a business from losing a productive employee.[55] When dealing with these businesses, policy makers must clearly demonstrate to businesses that making provisions for workers to participate in elder care is actually "an investment in the company's productivity and future earnings".[56] That is, by allowing, for example, workers to have more flexible hours, ability to work from home and financial provisions to help their employees pay for care during the working hours, a business is going to have less financial losses than if they lost a worker completely. Businesses will not have the search and training costs associated with hiring new workers. Also, businesses can retain their most senior and experienced/efficient workers. British Telecommunications (BT), for example, is producing tangible evidence to illustrate this point. Their flexible work policies make multiple provisions for their employees who have caregiving duties – this includes allowing them to work from home, emergency leave, and eldercare benefits. In retaining employees with these provisions, "BT has a 20% increase in overall production, savings of $375 million CDN (minimum recruitment costs are over $20 000 CDN per

[55] Ontario Ministry of Health and Long-term Care (2009).
[56] Ontario Ministry of Health and Long-term Care (2009).

employee).[57] Employers will benefit should they be encouraged by the government to offer more employee help programs that help them manage work and family duties.

Policy makers must look at all the effects employment and income status might have on caregiver. As previously discussed, some scholars believe a high income/economic status might be indicative of a lower opportunity cost since the household will be better able to afford to care for an elder due to their affluence (either by hiring more services to supplement their informal caregiving or enabling a family member to give up employment entirely to care since they can afford to forgo these wages for a time).[58] The authors Carmichael, Charles and Hulme (2010) have an important discussion that warns: 'a trade-off between employment participation and willingness to care also suggests conflicts between policies geared towards full-employment and policies relation to the provision of long-term care'. This means that government should cross-reference their elder care polices with their full-employment policies because they could work against each other. The sort of contradictory policies government should be wary of, for example, would be that encouraging employees to choose to provide more informal care will affect full-employment policies if the government is not careful to fill the holes in production that caregivers leave and work together with employers to stabilize their productivity and Canada's unemployment rate.[59]

Given their multivariate analysis of British Household Panel Survey for the years from 1991-2005, they find the link between 'employment status and transitions into informal care' indicates 'the likelihood of becoming a carer is significantly and

[57] Ontario Ministry of Health and Long-term Care (2009).
[58] Carmichael, Charles and Hulme (2010).
[59] Carmichael, Charles and Hulme (2010).

negatively related to prior participation in paid employment and hourly earnings'.[60] This means that an individual is more likely to provide care to an elder in an informal care setting if they have no prior employment or are earning low enough wages. In having a policy that provides labour support such as flexible hours, supplemental caregiving allowances and partnerships with businesses to encourage more accommodating working arrangements, the government will be able to lower the opportunity costs for each individual, thus encouraging the decision to provide informal care to an elder.

[60] Also of note: likelihood increases with age and declining health i.e. people with poor health more likely to be carers themselves.

# 6 Solutions and Priorities for Canada

## 6.0 Introduction

Expanding the informal care sector and encouraging appropriate use of formal care while also maintaining the effectiveness and sustainability of each form of care is a difficult goal for policy makers to achieve. There are several policy options that are viable in Canada and have been tried and analyzed in other westernized countries or even suggested by Canadian interest groups. Employment Insurance (EI) provisions and tax and pension credits are three options that must be given major consideration when deciding on elder care policy. Policy makers must also be aware, in addition to the immediate outcomes of elder care policies, why making policies about elder care now will enable the health care system to better face the elder care crisis in the future.

## 6.1 Employment Insurance (EI)

EI is meant to provide "temporary financial assistance" to eligible Canadians.[61] EI has been a vehicle for enhancing social Canada by introducing benefits for employees who are in circumstances that have negative impacts on their employment situation. The Compassionate Care Benefit has been described by Health Canada as a 'labour market policy' whereby the government hoped that creating this EI program in 2004 would promote human capital growth and a strong workforce. [62] However, the current policies are failing to do this because the programs lack proper support and assistance necessary to help caregivers who are also engaged in paid employment. The Compassionate Care Benefit program is only accessible to individuals who qualify for EI, which excludes any

[61] Service Canada (2011).
[62] Osborne and Margo (2005).

temporary, part-time or seasonal workers as well as the unemployed. Together, this accounts for 37% of Canadians not qualifying for help for compassionate care benefits.[63]

Aside from the lack of support for 37% of Canada's population, the compassionate care benefits program is still severely underutilized by the remaining 63%. The reason for this can be explained either by lack of awareness (which can be easily rectifies by public education programs)[64] or, more probably, the other limitations of the compassionate care leave benefits. An individual applying for EI must also prove that their regular (weekly) earnings have decreased by more than 40% since engaging in providing care and accumulated 600 insured hours of work in the past 52 weeks.[65] The number of insured hours is especially problematic when we see that other Canadian EI programs require less insured hours of work to qualify.

There are also labour code limitations. No provinces in Canada provide job protection for individuals who seek Compassionate Care Benefit.[66] [67] If the government wants individuals to stay in the workforce and alleviate pressures on the formal health care system by encouraging informal care, EI must be more accommodating to potential caregivers.

The glaring flaws in the EI compassionate care leave are explored in the Senate Report of 2009.[68] The report agrees with other reports that the eligibility and length of leave is insufficient. Also, the eligibility requirement that a family member must have medical proof of an elder dying within twenty-six weeks is not useful to many due to the

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[63] Osborne and Margo (2005).
[64] Osborne and Margo (2005).
[65] Service Canada (2011).
[66] Osborne and Margo (2005).
[67] Alberta, British Columbia and the Northwest Territories do not provide job protection
[68] Senate of Canada (2009).

unpredictable nature of death when dealing with illness.[69] It is rare for physicians to make predictions of death for an individual unless absolutely certain the timeframe. Not only does there have to be certain death, but leave only lasts a maximum of six (paid) weeks. This leaves hardly enough time for families to give appropriate care or set up care in an institution since many wait lists exceed three months. To truly partake in caregiving, it seems that the only alternative is to take unpaid leave or quit work. Solutions to these issues have been suggested by the Health Canada report on Compassionate Care by Osborne and Margo (2005). A physician is much more able to predict death given a 26-week window and benefits should last for 16-weeks, not six. In having a longer benefit period, this will allow individuals to care for their elder 'at the most critical stages of illness'.[70]

Another flaw is the 'two-week waiting period before receiving benefits'. This prevents caregivers from receiving financial assistance when they need it most to pay for care. Given the previous discussion on the risk of financial instability when giving care and that in order to qualify for EI there must be proof that earnings have dropped by 40%, this two-week waiting period is hard on caregivers who are already financially weakened. The immediately forgone wages to care and must wait for even partial compensation. Depending on the economic status of some households, this waiting period will decrease the likelihood of using the EI program and by extension, the likelihood of using informal care before formal care.

A benefit of the Compassionate Care Benefit program is that it eases the economic burden for women who are currently in the workforce. Since they are still the

[69] Osborne and Margo (2005).
[70] Osborne and Margo (2005).

major caregivers in the average Canadian household, circumstances forcing women to leave the labour force to care for an elder not only creates financial stress on a household by reducing income which may or may not be the only income for the household. This also drains skills and talent from the labour force while simultaneously decreasing the labour force participation of women which is inequitable.[71] The 71% of the total Compassionate Care Benefit recipients are women – if the government were to rectify the flaws pointed out by the Senate report, the status of women in the workforce will be noticeably improved as will the framework of informal care.[72]

The Canadian Senate (2009) report gives recommendations for correcting EI labour force participation deficiencies. For example, the report suggests focusing on labour 'standards' that will provide a stable relationship between labour participation and caregiving. Changing the labour code to provide paid leave for caregivers would help job retention and depress the costs of training and hiring new workers to fill vacancies.

In much the same way that maternity leave and workers compensation had to be built into the labour code, so does elder care. Currently, individuals who want to care for an elder at home must quit their jobs. Although one or two workers leaving a business may not have a visible impact on production in 2011 and many workers may not even be asking for employment flexibility to help them care for an elder, when the baby boomer generation requires care from family members willing to provide it, businesses will be feeling their losses more heavily. Putting a policy in place now will give enough time for the system to be perfected and prevent a workplace crisis from occurring when the elder care labour policy is really needed.

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[71] Senate of Canada (2009).
[72] Osborne and Margo (2005).

## 6.2 Caregiver Relief

The Ontario Caregiver Coalition published a pre-budget submission to the standing committee on finance and economic affairs in 2011 that detailed the need for respite care services for caregivers. The Coalition cites Human Resources and Skills Development Canada saying that caregiving is a physical and emotional drain on caregivers causing stress, depression and burnout. This can lead, not only to the elder person being placed in the formal care sector prematurely, but possibly the caregiver themselves being institutionalized. This can only cause undue pressure on acute care waiting times for the former and congestion costs in the health care system for the latter.

Increasing the accessibility, scope and flexibility of respite care in communities as well as increasing access to information services and income support for caregivers (regardless of labour market participation) will ease the stress on the formal health care system and possibly delay institutionalization of elders. Ensuring that caregivers in the informal care sector are better supported financially and emotionally will prolong care at home. The government should desire this outcome to reduce strain on the public health care budget in the future. Providing easily accessible information to caregivers on how to care for elders with different disabilities will decrease the number of hospital visits and emergencies and, by extension, decrease wait times in the emergency rooms, institutionalization and anxiety for caregivers. This is so important because informal caregiving is provided by family members who are not trained to take care of an elder.

If the inconsistency and lack of respite services across Canada were addressed, this might solve the 'major bottlenecks in hospitals' that are, according to the Auditor General

of Ontario, caused by 'insufficient home-care services'.[73] If these home-care services were accessible, it would have resulted in discharging 50% of elders in hospitals six days earlier.[74] The long ranging effects of home-care services are a significant decline in wait times, for surgery, emergency services, and acute care.

## 6.3 Tax Credits and Pension Schemes

Janice Keffe from the Nova Scotia Centre on Ageing[75] made a case for supporting informal caregivers by providing direct payment allowances for expenses and indirect compensation like tax and pension credits to prevent long-run financial trouble for caregivers.

Even if the government's role was to be an 'enabler of choice' like the role described in Pamela Fancey's 1999 paper, by providing more financial support and accommodate employment issues, the choice to provide informal care will be less distorted and perhaps even encouraged. Here, again, the pressures on the formal health care system will be eased considerably while also adding to social welfare because financial troubles will not dictate any particular form of care. Being able to 'recognize the costs involved in providing care' will be necessary in using 'indirect compensation policies' like tax credits and pension provisions.[76]

The choice to provide informal care to an elder at home depends on, not only the previously discussed losses in wages, but also losses in payment to their pension plans. An individual might choose not to provide care because a hiatus from work might mean

[73] Ontario Caregiver Coalition (2011).
[74] Ontario Caregiver Coalition (2011).
[75] Senate of Canada (2009).
[76] Fancey (1999).

lost investment for their retirement. A pension policy is an indirect transfer of funds that will preclude any distortions in informal care decisions due to pension concerns.

Norway, for example, is a country that uses pension support. Norway offers unmarried caregivers who have been out of the work force for five years support in the form of 'post caregiving pensions from the National Social Insurance Fund'.[77] Another form of pension policy used by Norway was pension credits. If an applicant could prove that they dedicated over 22 hours of care per week to an elder for six months they can receive at least three 'pension credits'. The credit value depends on their earnings previous to providing care.[78]

Tax, pension, and social security credits and benefits are viable alternatives to compensating caregivers in Canada. In her paper on compensating family caregivers, Fancey examined the 'adequacy, equity and sustainability of these initiatives' within a North American context. She concluded that flaws in the data make it difficult to assess whether tax and pension policies are worthwhile. Based on her theory, however, she concludes that tax credits can be used to fortify the informal care sector while also enabling shared costs among family members rather than full reliance on public funding. However, pension policies seem to have no proven behavioural effects on the choice to provide informal care. According to Fancey, the pension provisions are perceived as given long overdue at a time 'when one's health and economic situation are reduced as a result of retirement and the normal aging process.'[79]

In the United States, there are several state policies that aim to encourage informal care by giving tax credits for full-time caregivers (California and Missouri gave $500 per

[77] Fancey (1999).
[78] Fancey (1999).
[79] Fancey (1999).

caregiver in 2001). The National Family Caregiver Support Program also gives money to states that give training, counselling, information and respite services to caregivers – in four years the program had given $125 million annually.[80]

When discussing pension provisions and retirement, it is reasonable to expect some link between caregiving and early retirement. The propensity for individuals to retire given they are caregivers depends on gender and the relationship between the caregiver and the elder. Dentinger and Clarkberg (2002) conclude in their study of retirement among caregivers that spousal care is the most significant relationship that can dictate retirement. They find that women caring for their spouse are five times more likely to retire than women who do not care for anyone. Men, they point out, are 50% 'slower to retire' when caring for their wives, possible because they view their caregiving role to include providing more financial stability. The authors also note that the indicators suggest male caregivers are less satisfied with their employment. One could argue this indicates their desire, yet inability, to retire instead of their desire to work in order to avoid caregiving responsibly.[81] If policy makers understand the effects caregiving has on retirement, they can form their policies to shape early retirement decisions to preserve public finances (like income taxes) and caregiving choices. By choosing early retirement in this way, there will be resulting losses of skills/talent and productivity compounded with the recent retirement and loss of skills of the baby boomers from the labour market.

[80] Van Houtven and Norton (2004).
[81] Dentinger and Clarkberg (2002).

# 7 Scotland: a case of free care

## 7.0 Introduction

In 2002, Scotland introduced its solution to the increasing elder care burden: Free Personal and Nursing Care. Under the Community Care and Health Act 2002, the Scottish government outlined a number of personal and daily services that would be covered entirely by the government. Some of these activities included nursing care, medication, and home outfitting provisions for safety devices and aids and hand rails. This care is a 'legal entitlement for all 65+ assessed to have needs and require services free of charge'[82]. The BBC reported that the number of people receiving care since the adoption of this Act has increased nearly 70% in the years following 2002.[83] Built into the free care are financial transfer of £145 per week for 'personal care costs of elderly people in care homes' and £65 per week nursing home care".[84] The Scottish people and politicians believe that the Act alleviated 'financial concerns of many' and is a necessary measure for improving elder care. The Scottish government has no plans to change the current system and is satisfied with the decision to provide free personal and nursing care for elders.

## 7.1 Scotland

Before Scotland implemented their free personal care policy they conducted several studies on the 'anticipated demand for personal care' and the 'substitution effects' that might occur with such a policy.[85] That is, they discussed the possibility that

[82] The Scottish Government (2010)
[83] BBC News (2006).
[84] BBC News (2006).
[85] Stearns and Butterworth (2001).

individuals will choose to use formal care when there is zero cost rather than informal care that has the several discussed opportunity costs. The study also explained that there could be almost no substitution because informal care is driven by more emotional factors such as familial commitment and availability even though formal care might be easier to access, informal caregivers will not change their decision to provide care.[86]

Only seven percent of the Scottish population that requires care actually pays for personal care out of their own pocket.[87] However, over 50% of payments are subsidized by government funds eventually.[88] In addition to this finding, the Stearns and Butterworth (2001) paper also notes that there are many individuals are not receiving enough care (or at all) when they should. By implementing the free personal care plan, it will guarantee individuals are receiving the amount of care they require regardless of financial limitations.

Overall, if Canada wanted to explore one extreme of government intervention in elder care provision, policy makers can look to Scotland for how to approach valuation studies and certain behavioural features to consider when developing a socialist health care policy.

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[86] Leontaridi and Bell (2001).
[87] Stearns and Butterworth (2001).
[88] Leontaridi and Bell (2001).

# 8 Conclusions

Predictions for an older population that will live longer with chronic conditions and need long-term care means that it is important for every country, including Canada, to address the main issues facing elder care in the health care system. Canada is not the only country that is projecting a surge in the number of people over 65 years of age in the next fifty years. Much of Europe and North America will have a large percentage of its population in the senior category. Planning for this eventuality, other countries like Scotland, Germany and the United Kingdom have developed national strategies on ageing and Canada must follow suit.

Informal and formal care should be working together to ease the growing pressures on the health care system. By encouraging care for elders at home, the government can decrease the wait times in acute care for LTC and ease hospital congestion. These effects will spill over to the formal care sector and will lead to a more sustainable and equitable health care. To encourage informal caregiving, the government should be working on relief/respite programs and re-invent labour policies like the Compassionate Care Leave in EI (expand benefits and ease the restrictive requirements) so that individuals are more likely to care at home for an elder first before using the formal care system. The government should also consider how elder care affects women in the labour force since they are the primary caregivers. Pension policies may be helpful in encouraging care at home because it will ease forfeiture of pension savings and wages.

Canada's public debt is growing and paying for elder care is becoming more expensive for the individual and the government. By implementing a universal LTC insurance similar to the system implemented in Germany, the financial burden will be

addressed for individuals considerably. If Canada acts now to correct the elder care system, public funds will be less likely to be unmanageable in the future.

The Canadian government faces several issues in creating a national strategy on elder care including the diversity in elder care definitions and data scarcity. Gathering information at the provincial level and basing elder care policies on the discussed theories from other countries will safeguard the free and universal health care system enjoyed by all Canadians.

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