Supporting Canadian Caregivers

Current and Future Policy Directions

by

Sarah Lauren Drummond

A thesis submitted in conformity with the requirements for the degree of Master of Laws
Graduate Department of the Faculty of Law
University of Toronto

© Copyright by Sarah Lauren Drummond (2010)
Supporting Canadian Caregivers

Current and Future Policy Directions

Sarah Lauren Drummond, B.A. LL.B
Master of Laws
Faculty of Law
University of Toronto
2010

Abstract

This thesis examines current Canadian social policies aimed at ameliorating the position of informal caregivers of terminally ill and elderly care recipients. Using an ethics of care theoretical approach, the thesis critically evaluates federal and provincial income tax regimes aimed at increasing the financial security of caregivers, and also looks at the shortcomings of the Compassionate Care Benefit offered through the federal Employment Insurance Act. The evaluation reveals that the benefit has a very low up-take compared with initial estimates, and offers some explanations for its low use. A review of the caregiver policies in three European countries provide additional background for the final chapter of the thesis, which offers concrete and incremental solutions to the problems with the current social policies in place. The aim of this thesis is not to suggest sweeping reforms, but to offer affordable, practical, and politically feasible solutions that can begin to make a difference in the lives of caregivers.
This project would not have been possible without the generous financial support of the Canadian Institutes of Health Research, and the Training Program in Health Law, Ethics and Policy.

I would like to thank my thesis supervisor, Professor Jennifer Nedelsky, for her ongoing guidance and commitment to this project.

I am grateful to my father, John, and sisters, JD and Katie, who have encouraged and supported my academic pursuits. I would also like to thank my friends and colleagues, in both Toronto and Calgary, for their support and enthusiasm for my work this year. In particular, my colleagues at the University of Toronto, Faculty of Law, Andrea Toews, Jennifer Olijnyk and Jan Jacob Bornheim for their assistance and friendship. I am also indebted to Joshua Krane and Nathan Hume, both of the University of Toronto, for their editorial assistance and thoughtful comments on earlier drafts of this work.

Finally, to my partner, Jon Keeler, for his love, patience and encouragement.
This project is dedicated to my late mother, Sharon Lea Drummond. Without her gift of the written word, this project would not have been possible.

today

some days she needs the wheelchair
to go to meals and waits
at the door of her room
for an aide to push her

other times she puts one foot
in front of the other, shuffles
hand over hand
along walls and furniture

today there is a knife in her hand
she calls from the bedroom door
to her daughter-in-law
where is the kitchen

she is everyone’s mother
everyone’s mother
mother

Sharon Drummond, Where it Began
(Windsor: Black Moss Press, 2006)
at page 78.
<table>
<thead>
<tr>
<th>Chapter</th>
<th>Title</th>
<th>Pages</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Tax Policy</strong></td>
<td>79</td>
</tr>
<tr>
<td></td>
<td>Regional Disparity</td>
<td>81</td>
</tr>
<tr>
<td></td>
<td>Conclusion</td>
<td>82</td>
</tr>
<tr>
<td></td>
<td><strong>CHAPTER 5: INTERNATIONAL PERSPECTIVES</strong></td>
<td>83</td>
</tr>
<tr>
<td></td>
<td>Economic Measures</td>
<td>84</td>
</tr>
<tr>
<td></td>
<td>Denmark</td>
<td>87</td>
</tr>
<tr>
<td></td>
<td>Sweden</td>
<td>90</td>
</tr>
<tr>
<td></td>
<td>Ireland</td>
<td>92</td>
</tr>
<tr>
<td></td>
<td>Analysis</td>
<td>95</td>
</tr>
<tr>
<td></td>
<td>Conclusion</td>
<td>97</td>
</tr>
<tr>
<td></td>
<td><strong>CHAPTER 6: POLICY OPTIONS FOR CANADA</strong></td>
<td>98</td>
</tr>
<tr>
<td></td>
<td>Framework for Policy Development</td>
<td>99</td>
</tr>
<tr>
<td></td>
<td>Considering Gender</td>
<td>99</td>
</tr>
<tr>
<td></td>
<td>An Ethics of Care</td>
<td>100</td>
</tr>
<tr>
<td></td>
<td>National Consistency</td>
<td>101</td>
</tr>
<tr>
<td></td>
<td>Caregiver Characteristics</td>
<td>103</td>
</tr>
<tr>
<td></td>
<td>Long-Term Financial Support</td>
<td>104</td>
</tr>
<tr>
<td></td>
<td>Pension Credits</td>
<td>104</td>
</tr>
<tr>
<td></td>
<td>RRSP</td>
<td>106</td>
</tr>
<tr>
<td></td>
<td>Immediate Financial Support</td>
<td>107</td>
</tr>
<tr>
<td></td>
<td>Income Tax Policy</td>
<td>107</td>
</tr>
<tr>
<td></td>
<td>Direct Financial Compensation</td>
<td>110</td>
</tr>
<tr>
<td></td>
<td>Employment Related Benefits</td>
<td>112</td>
</tr>
<tr>
<td></td>
<td>Taking Care of the Caregiver</td>
<td>117</td>
</tr>
<tr>
<td></td>
<td>Indirect Support for Caregivers</td>
<td>120</td>
</tr>
<tr>
<td></td>
<td>Public Provision of Care</td>
<td>120</td>
</tr>
<tr>
<td></td>
<td>Universal Prescription Drug Insurance</td>
<td>121</td>
</tr>
<tr>
<td></td>
<td>Governmental Responsibility for Policy</td>
<td>122</td>
</tr>
<tr>
<td></td>
<td>Developments</td>
<td>124</td>
</tr>
<tr>
<td></td>
<td><strong>CONCLUSION</strong></td>
<td>125</td>
</tr>
</tbody>
</table>
Concluding Thoughts ................................................................. 126
Signs of Change for the Future......................................................... 127

APPENDIX “A” – DEFINITIONS OF “FAMILY MEMBER” ........................................ IX

APPENDIX “B” - ACCESS TO INFORMATION REQUEST .................................... XII

BIBLIOGRAPHY .................................................................................. XVII
Introduction

Dependents require care. Neither the utterly helpless newborn who must be cared for in all aspects of her life nor a frail, but functioning elderly person who needs only assistance to carry on with her life, will survive or thrive without another who meets her basic needs [...] Dependency is inescapable in the life history of each individual.¹

So begins the book, Love’s Labour by Eva Feder Kittay. She then offers both a theoretical orientation and a deeply personal account of her own experiences with what she describes as “dependency work”. It is from this starting point that I also begin, albeit with a somewhat different trajectory. Kittay’s focus, tied to her own experience of raising a severely handicapped child, looks at how justice in society is tied to the way in which the social and political order organizes the care of dependents. Kittay’s most valuable contribution to my own work in this thesis is her description and acknowledgement of the secondary dependencies that arise from care work: justice is not only about taking care of ailing or otherwise dependent members of society; it is also about taking care of the caregivers. A society that ignores the needs of caregivers brings about the same injustices as one that ignores the dependents themselves. This thesis specifically addresses the social policies that support, or in many cases, fail to support informal caregivers of terminally ill and frail elderly members of Canadian society. It concludes by offering policy solutions that will improve our ability, as a society, to take care of our caregivers.

This introductory chapter situates the entire thesis within the current Canadian socio-political context, and ties social policy to ideas of justice. It then moves to thinking about the caregiver as an autonomous individual, and the harms that are visited on a caregiver who is not properly taken care of. The chapter then offers a brief overview of the goal of this thesis, as well as the organization of the thesis.

---

¹ Eva Feder Kittay, Love’s labor: essays on women, equality and dependency (New York: Routledge, 1999) at 1, 28.
Socio-Political Context

The neo-liberal framework that shapes social policy in Canada is premised on the assumption and expectation that adult members of society participate in the labour market. To that end, universal benefit programs such as maternity and parental leave, benefits provided to informal caregivers, and the public pension plan, premise eligibility on attachment to the labour force on the part of the recipient. Events that interrupt the labour market participation of a member of society are viewed as exceptional risks, insured against through a federal employment insurance program. Such events include childbirth and early childhood parenting, periods of short-term disability, and the provision of care to a dying family member. Likewise, monetary social supports for such events, through credits and deductions offered by the income tax regimes both federally and provincially, are also premised on labour force attachment, by tying benefits to taxable income earned in the labour market.

Tying social benefits to labour force participation does not reflect a care-based conception of justice, because it does not adequately allow caregivers to fully participate in society and ignores the essential contribution of caregivers to the social order. Those who care for dependents, whether children, the frail elderly, or the terminally ill, are marginalized by a state that inadequately recognizes, acknowledges and considers worthy their work. Unless a caregiver can balance paid employment with her caregiving obligations, she is not entitled to the range of social benefits available to her working counterpart. A caregiver who devotes her full time and attention to her care work not only fails to receive financial support, but is further marginalized because she cannot participate in society to the same extent as other members of society. That is unjust because every person who enters the market as a

2 I avoid the term ‘citizen’ though this thesis, as a synonymous descriptor for ‘member of society’. In the context of recognizing rights and the delivery of social benefits, the concept of “citizenship” itself is contested. Many caregivers do not have the rights attached to citizenship, in the legal sense; though are full members of society in all other aspects, though economic contributions, and most notably in the context of this thesis, their contributions of care.
3 Female pronouns will be used throughout this thesis to refer to both caregivers and care recipients. As discussed in Chapter 2 of this thesis, caregiving work is predominantly performed by women.
worker - a member of society worthy of social benefits - requires care. As the passage at the outset of this chapter aptly notes, infants are not born with the capacity to care for themselves; likewise, at the end of life, dependencies are normal. By failing to acknowledge caregiving as an inherent and necessary part of the life-course, the current social order insufficiently acknowledges dependency, and in effect, takes for granted that its members appear at the age of eighteen, ready to work, and disappear some fifty years later, with little regard to what happens before or after that period of time. Not only does this socio-political framework inadequately recognize dependency, it does even less to recognize or acknowledge the secondary dependencies that arise on the part of caregivers. A caregiver who provides care to a dependent is inevitably restricted in her capacity to engage in paid labour because of the demands of her caregiving work. The result is that social benefits which purport to support caregiving work, but for which eligibility depends on labour force attachment, may not actually help the caregivers who require support.

Identifying the Harm – A Personal Anecdote

Reflecting on the context within which the secondary dependencies of caregiving arise, it is also important to think more specifically about the situation of the caregiver herself. What harms result because she is inadequately cared for the state? How does this harm, not only her, but society at large? In order to situate this piece, I offer a personal anecdote. I sketch the character of Mary, who is a fictional amalgam of the women in my family who have been caregivers: my mother, my grandmothers, my aunts, and my cousins. All of the women were differently situated and had varying responsibilities and obligations as caregivers. Thinking through the personal experiences of these women helps show the true harms caused by ignoring care work in our society.

Mary was 53 when her parents came to live with her in Saskatoon. They moved back from Florida, where they could no longer look after themselves because of her mother’s dementia. Shortly after they moved in, Mary’s father was diagnosed with
stage III prostate cancer and began radiation treatment. Her mother’s dementia progressed quickly and she soon became violent with other family members in the house: Mary’s husband, her sixteen year-old daughter, and twenty-year old son. Mary and her father made the difficult decision to institutionalize her mother.

Before they moved in with her, Mary worked part-time, from home, as an editor for a publishing company. As a contract employee, she was not entitled to prescription drug insurance or any other extended health benefits. Her husband worked full-time, her son was in university, and her daughter still in high school. Before they moved in with her, Mary and her husband had been actively involved in their church, attending weekly. Mary had even scaled her work back in the preceding years, a gradual retirement, and was participating more with charitable activities organized through the church. Her life was quickly turned upside down: every day, she drove her father to visit her mother; drove him to doctor’s appointments, radiation, and eventually chemotherapy and long stays as an in-patient at the hospital.

On top of tending to her parents, Mary was still working twenty hours a week, but found herself staying up later and later each night to get her work done. By the time Mary’s father died three years after he moved in with her, Mary had not been to church more than twice a year on holidays, to see her friends more than once or twice a month, or on a vacation since her caregiving began. Mary’s physical health suffered: she developed ulcers, migraines, and her previously stiff joints were now arthritic. Her caregiving had taken a toll on her marriage, too. Her husband was able to take on some responsibilities around the house, but not before a number of stressful and heated arguments between them. Because she and her husband both scaled their work back to accommodate their care obligations, and paying for a daily aide for her mother, Mary’s finances suffered. After her father died, rather than retire, she returned to work full-time, in an effort to save enough for her retirement.

While this anecdote is a fictionalized account, it is not an implausible scenario. There are also a number of variables that make Mary’s situation much better than the situation of many of her fellow caregivers: Mary was able to afford to work part-time
during her caregiving, her children were self-sufficient for the most part, she had a spouse for both financial and emotional support during her time as a caregiver. On a more global level, Mary’s privileges situate her better than many caregivers: Mary’s first language is English and she is not a visible minority, she is educated and can understand doctor’s instructions, she has a home that was big enough for her father to live with her, she owns a car to drive to and from appointments, and she lives in an urban centre near hospitals and doctors.

Putting a face to the caregivers that the social policies discussed in this thesis are intended to address can help show how ignoring, or inadequately recognizing, caregivers can be harmful. As Mary’s story shows, caregiving responsibilities can seriously impact the ability of a caregiver to participate in civic society the same way as non-caregiving members of society. It is this harm, the loss of one’s voice that occurs as a result of exclusion from social life, that aggravates the injustice of a social order that fails to acknowledge and support caregivers. As Chapter 2 outlines in more detail, the physical burdens associated with caregiving are significant. Caregivers, then, face the dual burdens of declining physical health as well as reduced participation in society. The economic costs resulting from the physical burdens faced by caregivers are visited on society at large, due to increased expenditures in the public health system and a reduction in economic productivity of caregivers.

Not only, then, are injustices done on caregivers through the burdens they face individually, but there is a collective failure of democracy when a society permits some of its members to be so overwhelmed that their basic rights of participation are unavailable to them.

**Aim of this Thesis**

This thesis evaluates a relatively narrow aspect of the dilemma of the needs of informal caregivers as secondary dependencies, and the political and theoretical
failures that give rise to the marginalization of caregivers in Canadian society. By focusing on caregivers of the elderly frail and terminally ill, it moves away from the more common assertions about dependency and secondary dependency that arise in the context of child-rearing. The argument that frames this thesis is that a society is unjust when it does not value or recognize the work of caregivers, and does not acknowledge their needs or the harms visited on them as a result of their caregiving. By focusing my analysis on the existing social policies that purport to support informal caregivers, this thesis will demonstrate that the current policy framework ignores the inherent and inevitable fact of both dependency and more acutely, the resulting dependencies and needs of those who care for dependents. These dependencies, whether they arise from infancy, disability, or age, all demand the work of informal caregivers, who are inadequately cared for in the current social order. There is no member of society capable of working without care, be it prior to, or after gainful participation in the labour market. By using an ethics of care perspective to ground both the evaluation of current policies and potential policy developments, this thesis draws on theoretical work that is still marginalized by both academia and policy-makers as being too costly and too far removed from existing norms championing individuality over collective responsibilities. However, I argue that incremental policy developments that express recognition to secondary dependencies on the part of caregivers can ameliorate, to a noticeable extent, the hardships of caregivers. By adopting this theoretical approach and by using it to make modest reforms to current policies, my goal is to outline a policy framework that provides caregivers with increased recognition and support. To the extent that theory can drive policy, and policy can drive theory, it is my ambition that even the most conservative developments to support caregivers can go some way to giving these caregivers the voice necessary to advocate for increased support and recognition of the necessary and under-appreciated work they perform.
Organization of this Thesis

This thesis is organized into six chapters. Chapter 1 examines caregiving in Canada, to understand who is doing it and how much is being done. It also explores the burdens associated with caregiving, with the goal of evaluating how social policies can be developed to specifically address those burdens. Physical, emotional and financial burdens are addressed, with the particular goal of estimating the monetary value of these burdens on both individual caregivers and society at large. To the extent that the overall health of a caregiver is compromised by her work as a caregiver, she will incur costs borne by society through both the publicly funded health care system, and her reduced contribution to the labour market.

Chapter 2 explores the theoretical underpinnings of the ethics of care to justify social policies supporting caregivers. The chapter begins with an overview of theories of justice and morality in the field of an ethics of care, and begins by looking specifically at the works of Joan Tronto and Mona Harrington. The approaches of these two theorists are evaluated in terms of their potential to assist in the development of social policy. Nancy Fraser’s ‘Universal Caregiver’ model is assessed, and I conclude that the value of her work for the purposes of my project lies with the reminder of how changes to social policy ought to be crafted carefully to ensure such changes do not entrench the marginalization of women or continue the relegation of care work to women. The chapter concludes with an overview of how the concept of autonomy fits with an ethics of care approach, and how autonomy is significant to care work because it fosters genuine rather than coerced care. A particularly significant contribution to this concept is the re-conceptualization of autonomy proposed by Jennifer Nedelsky, whereby the relational nature of human interactions are not only acknowledged, but integral to the meaning of autonomy. Acknowledging the inherent interdependence amongst us, and promoting this

reconceived notion of autonomy are of paramount importance when developing adequate policy solutions.

Chapter 3 explores the policies currently in place to provide income support to caregivers in Canada. Three policies are discussed: the Compassionate Care Benefit (the “CCB”) offered through the Employment Insurance Act (the “EI Act”); federal and provincial income tax regimes providing benefits and credits to caregivers; and the Caregiver Allowance offered since 2009 in Nova Scotia. The eligibility criteria for each benefit will be outlined, along with the value of the benefits. As an adjunct to the discussion of the CCB, the chapter also reviews provincial employment standards legislation across the country, which provide protected absences from work for caregivers who may, or may not, also be eligible for the CCB. The chapter also uses information from an access to information request to demonstrate the current uptake of the CCB across the country, including gender discrepancies in the use of the benefit.

Chapter 4 examines the current policies for income support in Canada against the theoretical foundations established in Chapter 2. In order to situate this evaluation, the chapter opens with an overview of the home care policies of Quebec, Ontario and Nova Scotia to demonstrate the level of publicly provided care, or lack thereof that gives rise to the demand for informal caregivers. In evaluating the current policies, the gendered implications of delivering the CCB through the EI Act are discussed, with particular attention to reforms made in the 1990’s that significantly reduced women’s eligibility for special benefits including the CCB. A recent study about caregiver experiences with the CCB will be used to show other shortcomings of the benefit, including an onerous and confusing application process, and the finding that the value of the benefit is inadequate. The chapter then discusses the regional disparities created by the split federal and provincial jurisdiction over paid leaves from work to provide compassionate care, with the result that in some provinces,

---

7 Employment Insurance Act, R.S.C.1996, c. 23, [“EI Act”].
employees may be entitled to the CCB but have no equivalent statutory right to a leave from work. Finally, the tax policies outlined in Chapter 4 are evaluated and critiqued as being insufficient to ameliorate in any significant way the financial insecurity of caregivers.

In order to develop innovative policy solutions, Chapter 5 surveys the policies in three countries to understand different types of benefit programs provided to caregivers. Denmark, Sweden and Ireland’s caregiving policies provide many examples that could be easily implemented in Canada, in modified forms. Policies such as caregiver allowances paid directly to the care recipient or caregiver, earning pension credits for time away from work on the part of the caregiver, and benefits that do not attach eligibility to participation in the paid workforce are some of the proposals that are generated in this chapter.

The final chapter develops concrete policy solutions based on the discussion in the preceding chapters. The chapter opens with a framework for policy development with the goal of ensuring that policies reflect four constant themes that emerged through the thesis. First, any policy changes must account for the significant contributions of women to caregiving work. Second, the ethics of care orientation that aims to make care work more equally distributed between the genders, and more valued by society as a whole, must be considered in developing policy solutions. Third, the practical implications of the split federal and provincial jurisdiction over caregiver benefits must be considered. Finally, consideration of caregiver characteristics, rather than the characteristics of the care recipient alone, must be considered in the eligibility requirements for new policies. The attributes of the care recipient are vitally important in determining eligibility for benefits and services provided to the recipient herself, but benefits aimed at the caregiver must, in some circumstances, look at the characteristics of the caregiver, either alone or in conjunction with those of the care recipient.

The policy suggestions advanced in Chapter 6 are four-fold: long-term financial support, short-term financial support, non-financial support and indirect support. The
long-term financial support recommendations include amendments to the Canada Pension Plan,\textsuperscript{9} and the registered retirement savings plan provisions in the federal Income Tax Act\textsuperscript{10} to provide greater long-term financial stability to caregivers.

Policy suggestions to enhance the short-term financial stability of caregivers include amendments to the CCB provisions in the EI Act to broaden eligibility requirements and increase the value of the benefit. Other short-term financial solutions include developing a universal caregiver allowance and increasing the value of income tax benefits by both broadening eligibility criteria and making the credits refundable. National adoption of the current Quebec tax policy of providing respite tax credits is also recommended.

Non-financial support targets the well-being of caregivers beyond their finances. The recommendations include developing and sustaining comprehensive respite programs and ensuring adequate and continued training for caregivers to ensure they are comfortable and competent to perform quasi-medical tasks as required.

Finally, the indirect supports proposed in this chapter aim to improve the situation of the care recipient, thereby reducing the burdens faced by their caregivers. In particular, the inclusion of palliative care services in the Canada Health Act\textsuperscript{11} and the adoption of a national universal prescription drug insurance program are both proposed as ways of reducing the demand on informal caregivers.

**Concluding Thoughts**

My aim with this thesis is not to reinvent the social order to make care the central concern for the lives of Canadians. As much as the ‘Universal Caregiver’ paradigm envisioned by Nancy Fraser would recognize and acknowledge the necessary work of care, such changes cannot be made overnight. Rather, realistic, affordable, practical,\textsuperscript{9} Canada Pension Plan, R.S.C. 1985, c. C-8.\textsuperscript{10} Income Tax Act, R.S.C. 1985, c. 1 (5th Supp.).\textsuperscript{11} Canada Health Act, R.S.C. 1985, c. C-6.
and above all, incremental changes are required over a period of time. Such incremental changes to policy can pave the way to greater recognition of the importance of care work, helping caregivers with the support they need to continue their labour of love.
Chapter 1: Caregiving in Canada

The term caregiving often conjures images of one person, a caregiver, assisting another person, a dependent care recipient. The acts range from those that promote basic survival: preparing food for and feeding the care recipient, to those that enhance the well-being, dignity and comfort of the care recipient, such as performing personal hygiene tasks. I propose that we view caregiving as an ongoing relationship between two adults, constituting varying levels of dependency and provision by each of the caregiver and care recipient. In this thesis, I will use the term caregiving to refer to this relationship of dependency as it relates to both frail elderly and terminally ill adults as care recipients.¹ I will also limit my analysis to informal, or unpaid caregivers, whether they are related to the care recipient or not. I also acknowledge that caregiving is not an isolated relationship between the caregiver and the care recipient. This relationship occurs in a broader context of family, neighborhood, community, and society at large. I will link these broader relations to my analysis of caregiving, although the primary focus of this thesis is on what I refer to as the primary caregiver, that is, the person who is primarily tasked with managing the care for a dependent and who often actively performs the care activities.

This chapter uses empirical evidence to ascertain the characteristics of caregivers in Canada. By understanding who provides care, and their circumstances, it will provide a basis from which to develop solutions to ameliorate the burdens faced by caregivers. The second section of the chapter looks at how caregiving impacts caregivers and discusses the physical, emotional and financial stress endured by caregivers. The third section examines the financial impacts of caregiving.

¹ The issue of care-recipients other than frail elderly and terminally ill adults, such as terminally ill or disabled children, is beyond the scope of this thesis. The policies and programs in place in Canada to support this type of care work differ to an extent that makes it difficult to evaluate in conjunction with care provided to adults. Also excluded is a direct analysis of the care work associated with periods of short-term or periodic disability on the part of otherwise healthy or able adults. To the extent that the policies and programs discussed in this thesis may apply to both groups of care recipients, they will be discussed, but no independent evaluation of this type of care work is undertaken.
distinguishing between the direct and indirect costs of informal caregiving borne by both the caregiver and other social institutions. Finally, the chapter discusses the demographic and political factors making caregiving an important issue now.

Who is Giving Care?

Various sources estimate the numbers of caregivers in Canada and describe their characteristics. A 2009 report produced by Human Resources and Skills Development Canada evaluated the work of unpaid caregivers in Canada with specific attention to caregivers who are also employed (the “HRSDC Report”). The HRSDC Report stated that 27.8 percent of employed Canadians are providing care for an elderly dependent, and 1.3 percent of employed Canadians provide such care in their own home. The remainder provide care to elderly dependents who live nearby or in another location altogether. The average caregiver reported providing eldercare for almost five years. Though the data is older, a 2001 study funded by the Status of Women Canada’s Policy Research Fund (the “SWC Report”) estimated that informal caregivers “provide as much as 80 percent of all the care needed by frail seniors.” Of the nearly 30 percent of employed Canadians providing care for elderly dependants, three-quarters are “middle-aged women who combine paid employment with the care of an elderly parent who has a chronic health problem.” The report also concluded that, of the employed Canadians providing eldercare, one-fifth are “single, childless women under the age of 35.” The HRSDC Report also examined

---

3 Ibid, at 9.
5 Ibid, at 9.
7 HRSDC Report, supra note 2, at 9.
8 Ibid.
employed Canadians in what they define as the “sandwich group”, that is, having responsibilities for both childcare and eldercare, and found that 16.8 percent of employed Canadians fit this definition.  

Caregivers gave two rationales for why they are providing eldercare. Just over half, 57 percent, reported “caregiving is a ‘labour of love’ (i.e., the individual wants to/chooses to care for their family member because they love them)” (emphasis in original). However, 40 percent state that “this is a role they take on because ‘there is no one else who can do it.’” The aspect of choice by caregivers and care recipients as to the provision of care is significant, and potential policy solutions must be sensitive to the wishes of caregivers and care recipients.

The Stress of Giving Care

Caregiving causes both physical and emotional stress for the caregiver. The HRSDC Report concluded that caregiver stress correlates to the amount of control the caregiver has over their role. The emotional support they provide is cited as the “most stressful dimension of their caregiving role because they found this role mentally exhausting and upsetting at the same time.” There are also significant physical burdens associated with caregiving. The HRSDC Report concluded that one-third of employed caregivers report “moderate to high levels of physical caregiver strain.”

The physical health effects associated with caregiving vary. One study evaluating the impacts of caregiving on caregiver health listed the symptoms reported by caregivers of seniors. They included sleeplessness, crying episodes and fatigue. Physical

9 Ibid, at 8.
11 Ibid.
12 Ibid, at 10.
13 Ibid.
14 Ibid, at 11.
15 Pamela Hawranik & Laurel A. Strain, “Always On-Call: The Health of Informal Caregivers for Seniors” (2002) 3 Research Bulletin of the Centres of Excellence for Women’s Health 8, online:
ailments including ulcers, headaches, stomachaches, hypertension and chronic pain have been reported as common amongst caregivers. Stress and guilt are common emotions for caregivers. Familial conflicts about who should provide what or how much care lead to increased stress. Stress is aggravated by the financial strain, discussed further below, that many caregivers face. Other stressors for caregivers include role overload, isolation, abuse, burnout and the perceived loss of one’s identity. The extent to which a caregiver perceives their role as stressful is influenced significantly by cultural factors, with some cultures viewing care work as necessary and normal within a family and others viewing it as a burden. The extent to which these cultural factors play a role in caregivers experience of stress and strain is beyond the scope of this thesis, but is important for policy-makers to consider cultural differences when creating programs to assist caregivers.

Caregiving may also place the caregiver at greater risk for certain types of injury, including back or other joint problems associated with heavy lifting. Bathing a care recipient is one of the more hazardous tasks of caregiving, due to the weight of the care recipient and physical weakness on the part of at least the care recipient and often the caregiver. Health care costs associated with the physical and emotional strains of caregiving are not insignificant, and are borne by society at large, with increased absenteeism from employment, reduced effectiveness as a caregiver, and

---

15 Canadian Women’s Health Network [http://www.cewh-cesf.ca/bulletin/v3n1/page4.html], [“Hawranik”].
16 Ibid, at 9.
19 Ibid, at 55-56.
20 Morris, supra note 17, at 94.
22 Armstrong 1, supra note 18, at 55.
direct health care costs. This will be discussed further below in the section detailing the financial costs of caregiving.

Before turning to the financial burdens associated with caregiving, I touch on a sometimes overlooked aspect of caregiving. As stated at the outset of this chapter, caregiving is a labour of love for half of those who do it, and by focusing on the half of caregivers that are distressed by their work as caregivers, we ignore the positive contributions that care work can have on a caregiver. Caregivers report satisfaction and gain from their care work, including personal and spiritual growth, as well as enjoying spending time with a loved one doing activities or sharing memories. Caregivers also feel rewarded by providing care that they initially did not think they would be capable of providing.23 Other common benefits to caregivers include feelings of increased resilience, greater patience, and stronger relationships with both the care recipient and other family members.24 These gains to caregivers can help offset some of the adverse physical and emotional consequences associated with caregiving. Despite the burdens of caregiving, it can be a highly rewarding and satisfying role for people, and to this end, it is important to ensure that the gains of caregiving can be increased or emphasized. Policies and programs that help caregivers achieve or recognize these gains will go some way to reducing the negative outcomes they may otherwise experience.

Financial Burdens of Caregiving

In addition to physical and mental stress, caregiving imposes a financial burden on caregivers. This section will discuss the direct and indirect financial costs associated with caregiving. Two causal factors are identified in the HRSDC Report as contributing to financial strain, a decline in income and an increase in expenditures.


24 Ibid.
A decline in income is attributed to the inability of most caregivers to work full time, and the increase in expenditures is attributed to paying for extra help, the cost of medicine, and an increase in living expenses.\textsuperscript{25} Two-thirds of employed caregivers face challenges in their paid employment due to their caregiving responsibilities, including the need to take time off work or reducing the hours they could spend at work.\textsuperscript{26} The SWC Report, which evaluated caregivers providing care to frail elderly dependants, undertook a more significant evaluation of the financial costs incurred by caregivers, dividing economic costs into those related to employment, those related to out-of-pocket expenditures, and the value of the unpaid labour they perform.\textsuperscript{27}

There are several ways that a caregiver’s employment earnings are impacted by their role as a caregiver. First, a reduction of work hours or unscheduled days off is inevitable. Second, caregivers may forego both private and public benefits that attach to full-time work, including extended health insurance and pension benefits.\textsuperscript{28}

Evaluating the costs of caregiving must also consider the long-term economic consequences of caregiving, including the loss of future income by caregivers who leave the workforce, reduce their employment, or decline promotions or transfers due to their caregiving responsibilities.\textsuperscript{29} To the extent that the care recipient has a low income or inadequate savings, the caregiver is more likely to absorb out-of-pocket expenses.\textsuperscript{30} Women are more susceptible to financial strains associated with caregiving than men, and are more likely to incur the long-term financial costs discussed.\textsuperscript{31} Financial strain is most significant amongst caregivers whose care recipient lives with them.\textsuperscript{32} The HRSDC Report found that caregivers in the so-called sandwich group face significant financial strain, finding, “[o]ne in three of the individuals in this group say money is tight in their family, which is consistent with

\textsuperscript{25} HRSDC Report, supra note 2, at 11.
\textsuperscript{26} Ibid, at 15.
\textsuperscript{27} SWC Report, supra note 6, at 3.
\textsuperscript{28} Ibid.
\textsuperscript{29} Ibid, at 3-4.
\textsuperscript{30} Ibid, at 47.
\textsuperscript{31} Morris, supra note 17, at 98.
\textsuperscript{32} HSRDC Report, supra note 2, at 11.
the fact that one in three have lower (i.e., $39,000 or less) personal incomes.\textsuperscript{33} While there is a correlation between financial strain and the care recipient living with the caregiver, this may not be causal, as it may be more common for those with low-incomes to choose a live-in care arrangement for the financial savings of maintaining only one household. With this brief overview of financial costs in mind, the next section turns to empirical evidence about both direct and indirect costs of caregiving.

\textit{Direct Costs}

The first set of costs to examine are those directly incurred by the caregiver in the course of their caregiving. A study evaluating the experiences of caregivers providing end-of-life care to both cancer and AIDS patients explored some of the costs associated with caregiving, specifically in the last month of the patient’s life.\textsuperscript{34} Though the study is limited in scope, it provides rich qualitative details about caregivers experiences. Participants were selected from British Columbia, Quebec and Nova Scotia, and were both formal and informal caregivers. The study looked at several separate categories of economic costs borne by caregivers including lost income, out-of-pocket expenses, and compensation. The study found that 24 percent of informal caregivers retired early because of their caregiving responsibilities, and just over one-fifth of informal caregivers reduced their hours of employment.\textsuperscript{35} Some caregivers made up for lost time following the death of the care recipient.\textsuperscript{36} Out-of-pocket expenses were reported by 63 percent of all caregivers, both formal and informal.\textsuperscript{37} Those costs included specialized medical items, or special clothing, food, drinks and other items for the care recipient.\textsuperscript{38} The average spent in the last month of the care recipient’s life was $240 for medical items and another $220 for additional

\textsuperscript{33} \textit{Ibid}, at 8.
\textsuperscript{34} Lorraine Greaves, et al., “Final Payments: Socio-economic Costs of Palliative Home Caregiving in the Last Month of Life” (Health Canada, Women’s Health Bureau, 2002) online: Centres of Excellence for Women’s Health <http://www.cewh-cesf.ca/PDF/cross_cex/final-payments.pdf>, [“Final Payments”].
\textsuperscript{35} \textit{Ibid}, at 42.
\textsuperscript{36} \textit{Ibid}.
\textsuperscript{37} \textit{Ibid}.
\textsuperscript{38} \textit{Ibid}, at 45.
items like the clothing, food and drinks.\textsuperscript{39} One of the most significant out-of-pocket expenses was travel, with 75 percent of informal caregivers having left their home to provide care.\textsuperscript{40} Caregivers reported travelling to different cities and provinces to move in with the patient and provide care. About 15 percent of informal caregivers received some form of compensation for their caregiving, but this includes gifts bequeathed by the care recipients in their wills.\textsuperscript{41}

Although this study looks only to the last month of a care recipient’s life, it revealed significant costs borne by caregivers. Given the average length of caregiving is approximately five years, it is reasonable to assume that costs are incurred throughout the caregiving period with a likely escalation as the condition of the care recipient deteriorates. Another significant finding was the number of caregivers who retired early for the purpose of caregiving, with the possible result of a reduced entitlement to future pension payments and fewer years in the workforce to accumulate savings for old-age. The travel-related costs found by this study are also interesting, as from a policy perspective, it will be important to consider that many caregivers and care recipients do not live with one another at the outset of the caregiving relationship. The next section will discuss in greater detail the indirect costs of caregiving, on both the caregiver and the social costs borne by society.

\textit{Indirect Costs}

In addition to the out-of-pocket and labour related costs of caregiving incurred by caregivers, the indirect costs of caregiving are important to consider too. There are two distinct measurements of the indirect costs of caregiving. The first is to assess the number of hours spent on informal caregiving to determine the value of the unpaid work. The second is to assess the costs associated with the reduced health and productivity of caregivers due to their care work.

\textsuperscript{39} Ibid.
\textsuperscript{40} Ibid, at 45-46.
\textsuperscript{41} Ibid, at 42, 46.
Valuing Informal Caregiving

It is estimated that between 85 and 95 percent of care provided in the home for the elderly is done so informally, which makes attributing a value to this work important when considering the significance of caregiving in Canada. Any attempt to place a dollar value on the unpaid caregiving of Canadians will be imprecise at best. There are variations between the different types of caregiving that may demand different valuations. Furthermore, due to the historic marginalization and devaluation of caregiving, it is impossible to identify an appropriate value to use as a benchmark representing the average monetary value of care. The value attributed to care will also depend on whether the replacement-value or opportunity-costs method of calculation is used. Other empirical difficulties arise when attributing value to care work, such as attempting to tease apart caregiving that benefits more than one care recipient, or a care recipient and small children. There is also the difficulty of teasing apart what is ‘care’ work, and what is an ‘ordinary’ household task that all Canadians perform and ought not to be included in the valuation. The incremental increases in time spent on such “ordinary” tasks to account for the fact that they may take longer or be more onerous due to the care recipient’s needs, cannot easily be pulled out of the evaluation. Others who have attempted the same valuation note that underreporting by caregivers may be a significant problem, because many view their care work as “a simple extension of their usual practices.”

Despite these difficulties, there are several indicators of the value of unpaid care work in Canada. Rough estimates by Statistics Canada suggest that the unpaid labour of caregivers in Canada was about $5 billion per year, on a replacement value basis, in 1998. Using the opportunity costs method, the value of informal care provided to

---

42 Morris, supra note 17, at 49.
household adults was estimated at $9 billion in 1998.\textsuperscript{45} Four years prior to this study, Statistics Canada evaluated the unpaid labour of women in Canada, including child and elder care as well as housework, finding the value to be between $234 billion and $374 billion per year.\textsuperscript{46}

The study discussed above, detailing direct costs of caregivers in the last month of care recipient’s lives, attempted to quantify the unpaid labour of primary and secondary caregivers for cancer and AIDS patients.\textsuperscript{47} The study took the average wage of a caregiver, at $16.91 per hour, and the average number of hours spent by the caregiver in the last month of the patient’s life, 340, to come up with the $5,749.40 of unpaid labour.\textsuperscript{48} The unpaid labour of other care providers was also estimated, with the primary informal caregiver indicating an average of 404 hours of care provided by others. This totals $6,831.64 in unpaid labour provided by caregivers other than the primary caregiver.\textsuperscript{49} From these calculations, which represent just the final month of the care recipient’s life, it is clear that the economic valuations using a replacement cost basis cited by Statistics Canada are likely within the appropriate range at around $5 billion per year. The next section looks at indirect cost incursions by non-caregivers, including employers and government institutions such as health care systems and the general tax-base.

\textbf{The Cost of Care to Society}

The second assessment of the indirect costs of caregiving is determining the costs to the economy at large incurred due to the strains of caregiving. This includes losses to employers due to absenteeism of caregivers, a reduction in the lifetime earnings of a caregiver who departs the workforce either periodically or permanently resulting in a decreased lifetime tax contribution, and health care or social services costs associated with the physical and emotional stress incurred by the caregiving as a result of their

\textsuperscript{45} Ibid.
\textsuperscript{46} Morris, \textit{supra} note 17, at 98.
\textsuperscript{47} Final Payments, \textit{supra} note 34.
\textsuperscript{48} Ibid, at 46.
\textsuperscript{49} Ibid.
care work. Costs are also associated with the use of social assistance programs or refundable tax credits by caregivers.

As with the assessment of the costs of caregiving by attempting to value the unpaid labour of caregivers, this assessment of social costs is even more difficult. It is practically impossible to conclusively identify the causal factors giving rise to a person’s lifetime contribution to the economy, whether it is lower than ‘average’ due to care of a child, the worker’s own ailments, or caregiving. Furthermore, health care and social services costs are likely to be incurred by the majority of the population regardless of their status as a caregiver or not. Any increases associated with an increased uptake of such services by caregivers are difficult to identify. There is evidence that caregivers do access the health care system more than their non-caring counterparts.50

Several health economists have looked at the costs of informal care from this perspective, measuring the cost of informal care by the loss of well-being of the caregiver.51 The benefit of this approach is that it captures the losses or gains experienced subjectively by the caregiver, in terms of their own utility. The simple way to phrase the question in this type of analysis is, “after one hour of caregiving, what is the financial cost of restoring the caregiver to their position prior to the hour of caregiving”? In one such study conducted in the Netherlands, the researchers concluded that the value of an extra hour of caregiving is about 9.3 or 10 Euros, equivalent to about 13 Canadian dollars. This cost is less than if the care recipient were receiving formal care at public expense, indicating an overall cost-savings to society by relying on informal caregivers rather than formal caregivers. Indeed, as explored further in the next section, the move to informal care in lieu of publicly funded care was certainly not an accidental move on the part of governments, but rather, in part a move to curb costs associated with health care expenditures.

50 HRSDC Report, supra note 2, at 39.
Why Pay Attention to Caregiving Now?

The preceding sections focused on the characteristics of caregivers and the economic costs associated with caregiving. This section will turn the focus to why caregiving is an increasingly important issue for Canadians. Six factors will be evaluated to demonstrate the increased importance of caregiving: imminent aging of the ‘baby boomer’ population, increased death from chronic disease, decreased fertility resulting in fewer caregivers, increased presence of women in the paid work force, increased life expectancy, and de-institutionalization policies. This section will discuss each factor, in turn, showing how they will all contribute to a high demand for care in the coming years, but that fewer people will be available to take on the role of caregiver.

Aging Baby Boomers

Following World War II, Canada, along with many other countries, experienced a ‘baby boom’. From the late 1940’s to early 1960’s, a disproportionately high number of babies were born. This created a demographic ‘bubble’, with declining birth rates since and an unequal spread in the population across various age groups.52

Baby boomers as an age cohort are now in their fifties and sixties, poised to retire, and many of them will face chronic health conditions, or a gradual decline in general health, and will require care. In 1999, the National Advisory Council on Aging released a report estimating that by 2020, 19 percent of the Canadian population will be comprised of individuals over the age of 65.53 The NACA Report concluded that, “this aging of the population is not a transient demographic phenomenon that will quickly fade away when the ‘baby boom’ generation is gone,” and found that most

Western countries will soon have a quarter of their population represented by seniors.\textsuperscript{54}

**Increase in Death from Chronic Disease**

The leading causes of death for Canadians provide insight as to how caregiving needs are changing. Life expectancy in Canada is increasing for both men and women, but the period before death is often marked by increased dependency as a result of their death being caused by a chronic, rather than acute, ailment. For example, death by suicide demands no caregiving, other than perhaps care for a mentally ill person preceding the death. Likewise, a sudden death by accident or heart attack does not implicate caregiving needs prior to death. On the other hand, cancer patients often require long periods of care, varying in intensity and duration. Periods of remission and relapse, as well as co-morbidity with other ailments can complicate care needs. Increases in Alzheimer’s disease and Parkinson’s disease also demand more caregiving. Advances in treatment and symptom management can alleviate some of the dependencies associated with these conditions, but it can also lengthen the period during which caregiving is required. In 2004, the leading causes of death for all Canadians were circulatory system diseases, cancer and respiratory system diseases.\textsuperscript{55}

**Decreased Fertility**

After the baby boom, there was a ‘baby bust’ beginning in the mid 1960’s marked by a low birth rate, which continues today.\textsuperscript{56} At the height of the baby boom in 1959 there were 116 births per 1,000 women aged 15 to 49 in Canada, whereas by 2002 the number had dropped to 41.\textsuperscript{57} The most significant drop in birth rate occurred between 1959 and 1970, when the number of births was 71 for every 1,000 women in

\textsuperscript{54} Ibid, at 4.
\textsuperscript{57} Ibid.
the 15-49 age range. Since 1970, the decrease to 41 has been steady. The result of the declining birth rate is that there are fewer people to provide care work, especially in contrast to the baby boomer generation.

Women in the Paid Work Force

The post-war period in Canada was not just marked by a baby boom, it was also a time of social change spurred by the women’s movement of the second wave of feminism. As women sought financial and social equality, they also sought participation in the paid work force. In 1976, women constituted 37.1 percent of the paid work force, and by 2006, this had increased to 47.1 percent. Another way to show the increase in women’s participation in the work force is the percentage of all women working. In 1976, 42 percent of women worked, and by 2006 the number increased to 58 percent. A greater proportion of women in the workforce means that fewer women are available to provide unpaid care on a full-time basis. It also means that if they do provide care, they may have both employment and caregiving obligations simultaneously, as the empirical evidence detailed at the outset of this chapter discussed.

Women’s participation in the work force is marked by a high degree of contingency. In 2006, 26 percent of all women in the paid work force worked part time, defined as fewer than 30 hours per work-week, while only 11 percent of men worked part time. Self-employment is also rising for women, with 11 percent of women in the paid work force working for themselves, though still outnumbered by men at 19 percent in 2006. Temporary work arrangements are also more common amongst women than men, with 14 percent of employed women and 12 percent of employed men in such an arrangement. The increased presence of women in the workforce

58 Ibid.
60 Ibid., at 6.
61 Ibid., at 8.
62 Ibid., at 9.
63 Statistics Canada 1, supra note 56, at 111.
means that the nature of their working arrangements must be considered in developing policy that aptly reflects their actual working circumstances.

**Increased Life Expectancy**

Canadians are living longer today than ever before. A child born between 2000 and 2002 is expected to live to age 83 if they are female, and 77 if they are male.\(^64\) Those born at the beginning of the baby boom, between 1950 and 1952 have a life expectancy of 66 for males, and 71 for females.\(^65\) Those born at the end of the baby boom, between 1960 and 1962 have a life expectancy of 68 for males and 74 for females.\(^66\) Contrast these numbers with just 30 years prior, with those born between 1920 and 1922, with men’s life expectancy at 59 years and women’s at 61 years.\(^67\) Steady increases in life expectancy have a number of implications for social policy, particularly if the age at which people leave the workforce is not increasing in lockstep. The period between an individual leaving the workforce and dying is extended significantly. In the late 1970’s and early ‘80’s, when those born in the 1920’s were nearing the end of their lives, the duration of care they required was likely much less than today. With a life expectancy hovering around 60 years of age, many people were still engaged in the workforce at the end of their life, and were not compromised by physical deteriorations that accompany old-age and create dependencies requiring care. Today, baby boomers are living well past retirement, nearing an average of 70 years old. Even in the absence of chronic illness, aging present difficulties and a person’s ability to function is often compromised by the frailty that can accompany old age. That is, baby boomers will start requiring care, and soon.

**De-Institutionalization Policies**

In addition to the changing demographics of Canadian society discussed in the previous subsections, changes to health and social service policies will also contribute

---


\(^{65}\) Ibid.

\(^{66}\) Ibid.

\(^{67}\) Ibid.
to a greater demand for caregivers in the coming years. Beginning in the mid-1980’s, provincial governments across Canada have been instituting de-institutionalization policies. Whereas dependants might previously have been hospitalized, or placed in a long-term care facility, they are now being sent home or to live with a friend or family member who will act as their primary caregiver. The shift to community based long-term care focused on dependents relying on a number of service providers for personal care, support and health services: family, friends and volunteers providing informal support, community support services provided by volunteers or through publicly funded programs, and formal publicly funded health and social services.\(^{68}\) It is estimated that only about one percent of seniors or those with disabilities currently live in institutions in Canada, a significant reduction from three percent a century ago.\(^{69}\)

In Ontario in particular, the policy rationales supporting de-institutionalization were driven by the projected increase in the number of seniors due to the aging population. The government perceived an inability to provide quality, integrated care to this growing segment of the population, and it determined that reform was required to develop lower cost alternatives.\(^{70}\) Advances in technology also assisted the move from hospitals to the home, as it is increasingly possible to perform day surgery and manage conditions on an outpatient basis.\(^{71}\) New drugs and equipment also make it possible for care recipients to remain at home.\(^{72}\) In addition to being perceived as a less expensive alternative, a great deal of empirical evidence supports the view that dependants prefer to be at home than in an institution, and as a result, government policy promoted active and independent living for seniors.\(^{73}\)

De-institutionalization policies have increased the responsibilities of caregivers, who are now more likely to be responsible for the management and coordination of care

---


\(^{69}\) Armstrong 1, *supra* note 18, at 59.

\(^{70}\) Baranek, *supra* note 68, at 15.

\(^{71}\) Armstrong 1, *supra* note 18, at 62.

\(^{72}\) Ibid, at 63.

\(^{73}\) Baranek, *supra* note 68, at 64.
services provided by third-parties and the provision of direct care to the care
recipient. Care recipients who were previously institutionalized now rely on informal
caregivers for a range of quasi-medical tasks, including the administration of
medication, use of intravenous lines and catheters and bathing and lifting.

The combination of the factors discussed in this section shows how caregiving will
become an increasingly important issue in the years to come. These factors also
indicate a shortage of informal caregivers, which is likely to result in caregivers
undertaking more responsibilities both within the home and in the employment
market, causing greater strain.

**Conclusion**

This chapter has illustrated who is giving care in Canada and it showed that
predominantly women provide informal care. This chapter also attempted to quantify
the financial costs associated with caregiving, both directly and indirectly. The direct
costs to the caregiver relate primarily to absences from paid work, and women are
particularly susceptible to long-term economic hardship as a result of their role as
caregiver. The evaluation of the economic costs associated with informal caregiving
also indicate that, on a broader level, informal caregiving is less costly to the state
than the provision of formal care. In this sense, there are savings to society when
care responsibilities are delegated to individual family members. To the extent that
there may be savings for the public at large, this chapter highlighted how the
delegation of care work to the private sphere has a negative impact on individuals. It
is this negative impact, to both physical and financial health of caregivers, that is the
focus of this thesis.

Finally, this chapter evaluated demographic and political factors that indicate an
increased demand for informal caregiving in the years to come. The goal of this
chapter was to identify the sectors of Canadian society that are most impacted by
policies targeting caregivers, in order to evaluate current policies and suggest new
policies to assist caregivers. The chapter that follows will provide a theoretical orientation that will be used in conjunction with the empirical data presented in this chapter to assess potential policy options for Canada.
Chapter 2: Theoretical Approaches to Care

This chapter presents a theoretical perspective to guide an evaluation of Canada’s current social policies supporting caregivers and will provide a framework for policy development. I have chosen an ethics of care orientation and I draw in particular on the works of Virginia Held and Joan Tronto. Virginia Held offers a comprehensive summary of the an ethics of care approach which I review in the first section of this chapter and this summary is helpful to situate the work of Joan Tronto, which I consider in the second section. The strength of Tronto’s work is her view that, to be helpful in changing social policy, an ethics of care must also be a political value. Tronto offers insight into how to transform what is otherwise viewed primarily as a theory of morality into a practical and applicable political ideal. I chose to use an ethics of care approach because it adequately accounts for the relational qualities of caregiving and does not prioritize market participation or individual achievement the way neo-liberal theories tend to. This approach is also helpful because it recognizes the significance of care work to society, and the significant burdens faced by caregivers in a social order premised on the model of social members being engaged full time in the labour market, as discussed in the previous chapter.

After reviewing the works of Held and Tronto, I consider the work of Mona Harrington in the third section. Harrington does not espouse an ethics of care approach, per se, but rather, she considers how to take questions of care seriously in a liberal democratic society. Harrington offers concrete ideas about social policy development that also reflect equality-seeking goals. Following the review of Harrington’s work, the chapter considers the ‘Universal Caregiver’ model posited by Nancy Fraser, as a glimpse into what may be possible with a political paradigm shift.

2 Mona Harrington, Care and Equality: Inventing a New Family Politics (New York: Alfred A. Knopf, 1999), [“Harrington”].
that values care work. The final section of this chapter includes a discussion of how autonomy can be integrated into an ethics of care approach.

Ethics of Care: An Overview

Over the last 30 years, a significant body of literature has developed to address perceived failures in the Kantian theories of justice than underpin social and political values in contemporary Western states. Starting with Carol Gilligan’s work, *In a Different Voice: Psychological Theory and Women’s Development*, feminist theorists began to describe an alternative theory, an ethics of care approach to morality.

Gilligan’s work was first published in 1982 as a response to Lawrence Kohlberg’s psychological analysis of moral reasoning differences between the genders. Gilligan stressed that women view relationships as interdependent and non-hierarchical. Gilligan concluded that, rather than justice, an “ethic of responsibility [is] the center of women’s moral concern, anchoring the self in a world of relationships and giving rise to activities of care.”

Gilligan’s work has been widely criticized on the basis that the ethic of care she describes is not gendered, but reflective of class and privilege. Nevertheless, the introduction of the ethics of care to feminist and philosophical literature generated a new field of social theory.

Virginia Held’s 2006 book, *The Ethics of Care* provides an excellent summary of the development of an ethics of care since Gilligan’s work in 1982. Held, like Tronto, envisions the political and social possibilities of the ethics of care. Her extensive overview of the ethics of care literature is a helpful place to define and understand the key elements of the theory. Held describes the ethics of care as constituting five distinguishing elements.

---

4 Carol Gilligan, *In a different voice: Psychological theory and women's development* (Cambridge, Mass.: Harvard University Press, 1982), [“Gilligan”].
7 See for example: Tronto, *supra* note 1.
8 Held, *supra* note 1.
First, the “central focus of the ethics of care is on compelling moral salience of attending to and meeting the needs” of those who are dependant on us. The ethics of care stresses the moral obligations on those who are faced with dependents requiring care, and rejects moral theories that emphasize independence and the ‘rational individual’ as ignoring a central concern of human life, that is, dependency.

The second distinguishing element of an ethics of care for Held is that it values, rather than rejects, emotion. Emotions including sympathy, empathy, sensitivity and responsiveness are important considerations in determining the demands of morality. Using reason and rationality as a guide to morality are insufficient in the ethics of care perspective.

Third, the ethics of care requires contextual and practical considerations, rather than abstract reasoning to ascertain the solution to a moral problem. In light of this approach, the ethics of care considers the relational nature of human interactions, and is dismissive of universal abstractions to guide moral decision-making.

Fourth, the ethics of care works to dismantle traditional distinctions between the public and private spheres. Dominant moral theories, argues Held, do not adequately deal with the moral significance of private spheres, including interconnections between people in family, friendship and social groups. The ethics of care attends to “moral issues arising in relations among the unequal and dependant, relations that are often laden with emotion and involuntary.”

The final distinguishing factor of the ethics of care is how people are conceived. Liberal individualism posits individuals as rational, autonomous, freedom-seeking beings. The ethics of care considers individuals to be inherently relational and

---

9 Ibid, at 10.
10 Ibid.
11 Ibid.
12 Ibid.
13 Ibid, at 11.
14 Ibid.
16 Ibid.
interdependent.\textsuperscript{17} The integration of autonomy with the ethics of care is more fully explored below, but the ethics of care does not necessarily dismiss the value of autonomy. Rather, the ethics of care views autonomy in light of the relational and interdependent character of individuals.

Held goes on to consider the distinction between the ethics of care and the ethics of justice. She notes that Gilligan’s work initially posited these two ethics as incompatible, but later work integrated both perspectives, acknowledging the importance of justice to care. That integration permits issues of equality to surface in the ethics of care perspective, and Held’s view is that, “there can be no justice without care,” placing care as the ultimate moral value.\textsuperscript{18}

Summarizing her overview of the literature on the ethics of care, Held offers her own view of what constitutes care. Care is both a \textit{practice} and a \textit{value} for Held. Central to the concept of care as a practice is the trust developed between people who care and the care recipients, and caring practice must emphasize trust. Care is also a value, meaning that the significance and importance of care work must be acknowledged and recognized socially and politically as such. Caring relations must be cultivated and nurtured to reflect the value of care in society.\textsuperscript{19}

\section*{Moral Boundaries: Joan Tronto}

Joan Tronto advances both a moral and political theory of care in her book, \textit{Moral Boundaries: A Political Argument for an Ethic of Care}.\textsuperscript{20} For Tronto, care must be made a prominent social and political ideal, acknowledging its universality and necessity to all people throughout their life-course. However, unlike other care

\textsuperscript{17} This is not unique to an ethics of care perspective. See for example Joan Tronto’s summary of the Scottish Enlightenment, which review the works of Frances Hutcheson, David Hume and Adam Smith, and their work on moral sentiments, Tronto, \textit{supra} note 1.

\textsuperscript{18} Held, \textit{supra} note 1, at 17.

\textsuperscript{19} Ibid, at 42.

\textsuperscript{20} Tronto, \textit{supra} note 1.
theorists, Tronto’s moral theory of care includes a political theory of care.\textsuperscript{21} This is where her work becomes critical to this thesis, as it moves the ideas developed by earlier care theorists into the practical realm of policy development. For this reason, I focus on Tronto’s conception of care as a political ideal.

In the final chapter of \textit{Moral Boundaries}, Tronto develops care as a political ideal. She envisions a paradigm shift, but rather than describing it as such, she suggests instead that we ought to consider it a shifting boundary. Permitting care to enter the "political," for Tronto, will allow us to not only change the status of care, but also, "the status of those who do caring work in our culture."\textsuperscript{22} Thinking of care as a political ideal will also enhance the democratic participation of all members of society. According to Tronto, “the practice of care describes the qualities necessary for democratic citizens to live together well in a pluralistic society, and that only in a just, pluralistic, democratic society can care flourish.”\textsuperscript{23}

In order to regard care as a political value, Tronto challenges the assumption that humans are always independent, or that independence is perceived as a norm for which we ought to strive. That idea is common among care theorists: the traditional moral theories of justice, and the consequent political order, are premised on humans as individual, autonomous beings, and conditions of dependency are exceptional.

For Tronto and others, dependency is a necessary element of the human condition. By their very nature, humans enter the world in a highly dependent state. Their dependency may wane as they approach adulthood, but other conditions of dependency present themselves throughout the life-course. Humans are also part of networks that demand care of them and their obligations to provide care detract from their autonomy. The universality of dependency demands us to view humans as interdependent, rather than to choose categories of autonomy or dependence to describe their condition.\textsuperscript{24} Tronto views the current political order as being highly

\textsuperscript{21} \textit{Ibid}, at 155.
\textsuperscript{22} \textit{Ibid}, at 156.
\textsuperscript{23} \textit{Ibid}, at 161-162.
\textsuperscript{24} \textit{Ibid}, at 162.
resistant to conditions of dependency because of the perception that it is opposed to the primary goal of autonomous living.25

Tronto also calls into question the public/private divide that places care in the private domain and outside the realm of social responsibility. She argues that, “[a] political ideal of care would force us to reconsider this delineation of life into public and private spheres.”26 Shifting the boundaries of political ideals to include care also requires us to consider ideas of social membership, and what makes an ‘ideal’ member of society.

Liberal and neo-liberal political orders are premised on a paradigm whereby social members are expected to participate fully in the labour force and where public good is achieved through participation in public spheres such as the marketplace. When the work ethic is prized as the ultimate contribution to social goodness, the care work involved in sustaining a productive, working person is obscured.27 Tronto sums up her position on the social citizenship aspect of care work by stating, “[a]s long as we accept "the work ethic" as a valuable cultural norm, then those who engage in activities of care, rather than activities of production, will not be deemed especially socially valuable.”28

After delineating how a change in perspective can help us to view care as a political ideal, Tronto demonstrates how current power relations in American society exemplify how care is not currently valued as a political ideal. Care work is most often performed, in the market at least, by those who are marginalized because of race, class or gender. The powerful are able to use their wealth to purchase care work, and are, "unwilling to admit their dependence on those who care for them."29 Those arrangements perpetuate the view that care is unimportant in the political arena and explains why care related policies garner such little political attention.

25 Ibid, at 163.  
26 Ibid, at 165.  
27 Ibid.  
28 Ibid, at 166.  
One of the ways to bring care in to the fore of politics is to empower the relatively disempowered, to whom care matters. By framing political issues in ways that matter to and impact people, they will be more inclined to speak out and become concerned with the political order.\textsuperscript{30} Using care as a political ideal will enhance democracy by bringing a political voice to those who have traditionally been silenced by the dominant political order. According to Tronto, “[c]are is a way of framing political issues that makes their impact, and concern with human lives, direct and immediate. Within the care framework, political issues can make sense and connect to each other. Under these conditions, political involvement increases dramatically.”\textsuperscript{31}

The benefit of Tronto’s work is the conception of an ethics of care in political rather than purely philosophical terms. This makes the theory more practical, because it is more easily used as a tool to evaluate both current social policy and suggested policy reforms. Her idea that framing political issues from this perspective will enhance democracy is perhaps overly ambitious, but provides an ideal to strive for in developing policy solutions. The most beneficial aspect of Tronto’s work, for the purposes of this thesis, is calling into question the assumptions about dependency that form the basis of the current social and political order. By taking seriously the inevitable dependencies that Tronto identifies, political and social changes can be geared in this direction.

The next section of this chapter will look to the work of Mona Harrington, who is also working to translate the moral theory of an ethics of care into a feasible political ideal to realize actual social and political change.

**Mona Harrington: Care and Equality**

Mona Harrington’s approach elaborates on Tronto’s work. In her book, *Care and Equality: Inventing a New Family Politics*, Harrington moves from political ideas

\textsuperscript{30} Ibid, at 177.
\textsuperscript{31} Ibid.
into very practical public policy approaches to valuing care in society. Though her focus is on the current possibilities in the United States, she offers insight that is also helpful in the Canadian context. This review will focus on some of the themes that Harrington adopts when developing policy solutions to care in a liberal society.

Harrington’s main goal in *Care and Equality* is to develop care as a national political value while also promoting women’s equality. Harrington identifies one of the main failures with current social policy in the United States as being the lack of, "any equality-respecting system to replace the full-time caretaking labor force of women at home." She then goes on to highlight the current economics of care provision, noting that those who require care are often forced to seek care in the market, but may not have sufficient resources to purchase adequate care. It is, in part, the reason for the low pay earned by caregivers in the market, who are often forced to take such work for lack of any other work.

The low pay of care-work exacerbates existing inequalities based on race, gender and class. The reason, of course, for needing to obtain care in the market is that women are increasingly working in the paid workforce, and can no longer provide care privately. Harrington echoes Tronto’s view that the solution to this problem lies in re-drawing the boundary between public and private responsibility. According to Harrington, the problem calls for, “a shifting of some responsibility for care to the society at large, some different allocation of caretaking costs, some new division of paid and unpaid labour. It calls for the adoption of care as a national political value.”

Harrington discusses how political action can take the problem of care seriously. First and foremost, the economics of care, including the unequal allocation of caregiving costs on women, must be acknowledged in the political realm. The preceding chapter of this thesis clearly demonstrated the unequal allocation of

---

33 *Ibid*, at 17.
35 *Ibid*, at 43.
36 *Ibid*. 37
caregiving costs and responsibilities on women. Next, Harrington posits that assuming care as a national political value means assuring good care to all members of society, in the same way that the state assures liberty, equality and justice to members of society. Drawing on Tronto’s conclusion that humans ought to be viewed as interdependent, and through their life-course will at times provide care and at other times will give care, Harrington promotes the idea of families as a place of intimate interdependence where care is both given and received. The interdependency of care, for Harrington, "contributes to the strengths an individual needs for the fullest development of personality and talent and also respect and concern for others." The connected, interdependent and relational aspects of the human condition are often overlooked by liberal policies, which not only view individuals as autonomous, but also view family units as private and autonomous in and of themselves.

Harrington suggests that conceiving of care as national political value will, "ask for contributions to good care from everyone in some way," whether they are an individual, government, business or family. The redistribution of care responsibilities on a more equitable basis, especially within families, acknowledges that care is a universal and necessary aspect of the human condition. The solution, for Harrington, is a blend of public and private, with defined obligations on the private sector for adjusting the current social paradigm’s focus on social members as workers, and profit maximization in the marketplace. Family-based policies, for Harrington, offer a progressive solution for Americans, where care can be undertaken by everyone, without foregoing participation in social and political life. Harrington’s ideas provide concrete policy ideas for a political paradigm shift that values care work.

37 Ibid, at 48.
38 Ibid, at 85.
39 Ibid.
40 Ibid, at 51.
41 Ibid, at 153.
In the next section, I will briefly review Nancy Fraser’s ‘Universal Caregiver’ model, which takes Harrington’s proposed paradigm shift and extends it even further.\(^{42}\) While I acknowledge the strength of Fraser’s model, I am of the view that it offers us an ‘ideal’, which cannot be readily achieved. That being said, the overarching principles guiding Fraser’s work can be helpful when considering policy changes to support Canadian caregivers.

### The Universal Caregiver

Nancy Fraser considers the ‘Universal Caregiver’ model as compared to the ‘Caregiver Parity’ model in *Justice Interruptus*. Fraser argues that many proponents of women’s equality, and many social programs in Western Europe, operate on the caregiver parity model. That model enables women who provide care to do so without incurring the costs associated with not fully participating in the market, and aims to make ‘difference costless’. Hallmarks of this model include social benefits for caregivers including caregiver allowances, means-tested tax credits, and a social insurance system that makes movement between care work and paid employment more attainable.\(^{43}\)

Fraser is critical of the model on the basis that it fails to prevent the marginalization of women because it reinforces the idea that care work is women’s work. It more sharply defines the gendered division of domestic labor. It also fails to ensure income equality as between men and women. Women are marginalized in the employment sector due to period of interruption to provide care, and their participation in politics and civil society is curtailed in this model.\(^{44}\)

As an alternative to the caregiver parity model, Fraser explores the possibility of a universal caregiver model. That model, according to Fraser, would “*induce men to become more like women are now*, namely, people who do primary carework”

\(^{42}\) Fraser, *supra* note 3.  
\(^{43}\) *Ibid*, at 57.  
\(^{44}\) *Ibid*, at 58.
This model would make care work central, rather than paid employment, and would "dismantl[e] the gendered opposition between breadwinning and caregiving". That would achieve gender equality by making women’s life patterns the norm for everyone, with everyone mixing both paid employment and care work.

To eliminate the strains currently faced by employed caregivers, social institutions including the employment sector would be re-modeled to accommodate the care work done by all employees. Shorter workweeks, greater publicly funded care, reliance on relatives, friends and the community would define the social order in this model. Those without "kin-based responsibilities" would participate in care work in "state-funded but locally organized institutions".

Fraser is skeptical about the possibility of the universal caregiver model becoming a reality in the near future, but argues that the vision of this model must guide reforms to social policy now. To the extent that I attempt to provide practical policy solutions in this thesis, I share Fraser’s skepticism of this model’s applicability to the current social order. However, I agree with her that having in mind a social order that can bring value care work above paid employment like she suggests in the universal caregiver model, is a helpful vision to guide policy development. The strength of considering Fraser’s work is also to notice her criticisms of the care-giver parity model, namely, entrenching the marginalization of women and relegating care work to women. As much as working toward a ‘Universal Caregiver’ model is appealing, perhaps the most practical way to use the model is to notice that it more equally distributes care work between the genders in a way that policies undertaken by a caregiver parity model do not.

---

46 Ibid, at 61.
47 Ibid.
48 Ibid.
**Integrating Autonomy**

As detailed in Chapter 1, roughly half of caregivers in Canada state that they provide care because no one else is able, reflecting a lack of autonomy on their part in the provision of care, raising questions about whether they are able to provide the best care possible to care recipients. Little empirical data is available to indicate whether care recipients choose their informal caregivers, or receive care from informal caregivers because they are unable to access other care that may be preferable to them. This section will address issues of autonomy as they arise within the ethics of care framework discussed above.

The primary concern for ethics of care theorists is individual detachment from their social and relational network. By contrast, ethics of justice theorists posit that threats to one’s autonomy are the cause for concern, and must be remedied. Carol Gilligan, for one, is dismissive of the importance of seeking autonomy at all, stating that seeking autonomy is, “a illusory and dangerous quest”.49 Grace Clement, on the other hand, considers autonomy to be critical for an adequate ethic of care. She addresses the significance of autonomy in her book, *Care, Autonomy, and Justice*, and finds that promoting autonomy is the only way to achieve genuine care.50 For Clement, threats to autonomy damage either the caregiver or the recipient of care, and care is distorted when the autonomy of either is lost.51

An apt response to this dilemma comes from Jennifer Nedelsky’s forthcoming work focusing on relational autonomy and justice.52 Nedelsky posits that reconceiving autonomy, rather than disregarding it, will give renewed meaning and importance to autonomy that can be complementary to an ethics of care perspective focusing on the relational quality of our lives. For Nedelsky, applying a relational lens to a traditionally western, liberal idea such as autonomy redefines the term in a way that is

---

49 Gilligan, *supra* note 4, at 48.
51 *Ibid*, at 27.
reflective of the inherent interdependencies of human life. Autonomy does not mean independence, in the sense most often applied in mainstream liberal political and social theory; it is rather, as Nedeslky puts it, “the core of a capacity to engage in the ongoing, interactive creation of our selves—our relational selves, our selves that are constituted, yet not determined, by the web of nested relations within which we live.”

This reconceived approach to autonomy, which is consistent with the inherent interdependence amongst us, can fit comfortably with an ethics of care approach that values and promotes relationships of dependence and the inherent vulnerabilities of human life. In evaluating social and political responses to caregiving, it will be important to keep in mind the importance of promoting autonomy on the part of both caregivers and recipients, by being mindful of their interdependence, not just amongst each other but within the larger social context.

Conclusion

This chapter opened with the promise to provide a theoretical orientation to guide policy development in Canada. Choosing an ethics of care approach, I outlined the approach using Virginia Held’s summary of the theory, to establish the theoretical underpinnings of an ethics of care. Then, I considered Joan Tronto’s contribution to the field, which incorporates an ethics of care as a political ideal, which assists in translating a moral theory into a theory with practical applications.

I then moved away from work that is explicitly within the domain of an ethics of care, to consider Mona Harrington’s contribution to care policy. While her approach is dominated by the American political landscape, she takes Tronto’s position that using care as a political value will bring about a paradigm shift that creates a social and political order more amenable to care work. Using both Tronto and Harrington to move away from a moral theory, these theorists both enunciate the shift from

\[53 \text{ Ibid, at 11.}\]
theory to ideas that can situate practical policy development. I then evaluated Nancy Fraser’s ‘Universal Caregiver’ model as an ideal-type model which is not readily practical but whose overarching principles can offer guidance in the policy development process. Using Fraser’s work is helpful because it positions the current socio-political order against an ideal, and permits policy developments to be assessed against such an ideal, even if the ideal is not readily attainable.

Finally, I assessed how notions of autonomy can fit comfortably within an ethics of care perspective, and why this is important when considering policy changes to support caregivers. Caregiving without autonomy on the part of either the care recipient or caregiver is not genuine care, and is not consistent with the actual relational nature of human interdependence. This chapter has offered an orientation from which to consider policy, and when considering the empirical evidence offered in Chapter 1, as well as the legislative frameworks discussed in the next chapters, will enable a critical evaluation of Canada’s current policies regarding care work in Chapter 4, and more importantly, will inform Chapter 6, the development of policy options in Canada.
Chapter 3: Income Support for Caregivers

This chapter will discuss three types of income support measures available to Canadian caregivers. First, the Compassionate Care Benefit (the "CCB"), a benefit offered through the Employment Insurance Act (the “EI Act”), will be examined. This first section will also look at provincial employment standards legislation which provide statutory leaves to caregivers.

The second section will describe ancillary income support measures for caregivers. This will include federal and provincial income tax credits as well as the caregiver allowance program in Nova Scotia. These ancillary income support measures are, for the most part, reflective of a more long-term caregiving relationship, rather than focus on end-of-life like the CCB. The provincial income tax policies of Quebec and Manitoba are discussed in greater detail due to the particular attention on caregivers in those province’s tax policy. The caregiver allowance in Nova Scotia is discussed as a new and unique program in Canada, though as will be seen in reviewing international solutions to caregiving in Chapter 5, similar programs have been in place in other jurisdictions for some time.

The Compassionate Care Benefit

The most targeted and direct financial assistance offered to Canadian caregivers is the CCB, which was introduced to the 2004. The CCB provides six weeks of employment insurance (“EI”) to employed individuals who need to take a leave from their employment to care for a dying family member. The 2003 Budget Plan, which explained the proposed budget in detail, stated that, “[t]he Government of Canada

---

recognizes that income support and job protection are key for workers who take often lose income and benefits due to time lost from paid employment.”

This section will detail the eligibility requirements for the CCB as well as provincial employment standards legislation which provide statutory leaves to caregivers. The second half of this section will explore current statistics about the up-take of the CCB received from an access to information request made in October 2009.

**Eligibility**

Eligibility for the CCB is similar to eligibility for other benefits offered through the *EI Act*, such as maternity and parental benefits. As an insurance scheme, eligibility is premised on workforce participation with the insurable risk being the interruption in or loss of employment. Eligibility for EI has traditionally been limited to employees whose employers pay their premiums. The federal government announced in early November 2009 that changes to the eligibility structure for EI benefits would be implemented in the next budget. On December 16, 2009, the *Fairness for the Self-Employed Act* received royal assent. Amendments to the *EI Act* permit self-employed people to voluntarily contribute to the EI regime beginning in January 2010, and entitlement to benefits would begin in January 2011. Parental, maternity, short-term disability and compassionate care benefits will be offered to those who voluntarily opt-in to the regime and satisfy the minimum insurable earning requirements, discussed further below.

**Insurable Earnings**

The *EI Act* distinguishes between “major attachment claimants” and “minor attachment claimants,” with only the former eligible for the CCB. In order to be a major attachment claimant, an individual must have worked at least 600 insurable

---

4 The access to information request and response from Service Canada are appended to this thesis as Appendix “B”.
6 *Ibid*, s. 152.03 – 152.06.
7 *EI Act*, supra note 1, s. 23.1(2).
hours during their eligibility period.\textsuperscript{8} An eligibility period is typically the year preceding the claim, or the period since the beginning of the most recent claim, if within the preceding year.\textsuperscript{9} The CCB is available once every 26 weeks.\textsuperscript{10}

**Decrease in Earnings**

In addition to requiring 600 hours of insurable earnings, applicants for the CCB must have experienced a decrease in earnings of at least 40 percent prior to their application.\textsuperscript{11} This requirement is problematic because it requires that the individual applying for benefits has reduced their work prior to being eligible for benefits. However, no job protection is mandated for employees who are required to reduce their employment, so this requirement may be impractical or impossible for employees to meet. Once an applicant can show that her earnings have been reduced by 40 percent for a week, either by an employer pro-rating a salaried employee or a reduction in hourly wages by forty percent, she can then apply for the CCB. As with all EI benefits, the applicant must serve a two-week unpaid waiting period prior to the commencement of benefits.\textsuperscript{12}

**Familial Relationship**

Amendments to the *EI Act* in 2006 significantly expanded the class of persons to whom care could be given by a person eligible to receive the CCB.\textsuperscript{13} Initially, only spouses, children and parents of the employee could be the recipients of care in order for the caregiver to qualify for the benefit. This resulted in a number of claimants being denied benefits, despite close relationships with the persons for whom they provided care. A number of cases where employees cared for siblings and

\begin{thebibliography}{10}
\bibitem{8} Ibid, s. 6(1).
\bibitem{9} Ibid, s. 8(1).
\bibitem{10} Ibid, s. 12(4.1).
\bibitem{11} Employment Insurance Regulations, SOR/96-332, [“EI Regulations”], s. 14(2).
\bibitem{12} EI Act, supra note 1, s. 13.
\bibitem{13} EI Regulations, supra note 11, as am. by SOR/2006-135, s.1, at s. 41.11(2).
\end{thebibliography}
grandparents were appealed, but denied on the basis of the clear legislative intent to limit the definition of family member.14

Since the amendment, a much broader class is eligible, including individuals whom the caregiver determines to be ‘like family’. Others included are wards or guardians of the caregiver or their spouse, aunts, uncles, siblings, and step-parents or foster-parents and step-children or foster-children.15

**Significant Risk of Death**

An employee claiming CCB must present a medical certificate indicating that the care recipient has a serious medical condition and a significant risk of death within 26 weeks from the date of the certificate.16 The care recipient must also require the care and support of one or more family members, as attested in the medical certificate.17

**What does the CCB Provide?**

Once an individual’s claim for the CCB has been accepted, a two-week unpaid waiting period is imposed prior to the receipt of benefits.18 Up to six weeks of benefits may be paid, and may be divided between eligible family members.19 If more than one family member receives benefits, the waiting period must only be served by the first family member to receive benefits.20 In the event that the care

---

14 See for example: In the Matter of the Employment Insurance Act and in the matter of a claim for benefits by Anglea Ings and in the matter of an appeal by the claimant from the decision of a Board of Referees given on December 20, 2005 at London Ontario (July 28, 2006,) Canadian Umpire Benefit no. 66451, online: Service Canada: <http://www.ae-ei.gc.ca/policy/appeals/cubs/60000-70000/66000-66999/66451E.html>; In the Matter of the Employment Insurance Act and in the matter of a claim for benefit by Donna Robinson and in the matter of an appeal by the Commission from a decision of a Board of Referees given at Windsor, ON, on the 13th day of October, 2005 (August 3, 2007,) Canadian Umpire Benefit no. 67803, online: Service Canada: <http://www.ae-ei.gc.ca/policy/appeals/cubs/60000-70000/67000-67999/67083E.html>; In the Matter of the Employment Insurance Act and in the matter of a claim for benefit by Ang Ly and in the matter of an appeal from a decision of a Board of Referees given at Kitchener, ON, on the 7th day of April, 2006 (May 10, 2007,) Canadian Umpire Benefit no. 66399A, online: Service Canada: <http://www.ae-ei.gc.ca/policy/appeals/cubs/60000-70000/66000-66999/66399AE.html>.
15 *EI Regulations, supra* note 11, s. 41.11(2).
16 *EI Act, supra* note 1, s. 12.1(2)(a).
19 *Ibid*, s. 23.1(8).
20 *Ibid*, s. 23.1(7).
recipient dies within the benefit period, benefits stop at the end of the week during which the person dies.\textsuperscript{21}

The recipient of CCB benefits receives 55 percent of her average weekly insurable earnings in the 26-week period preceding her claim.\textsuperscript{22} The maximum weekly benefit is $457, which is taxable.\textsuperscript{23} A CCB recipient may be entitled to a family supplement if her annual family income is lower than $25,921. The recipient or her spouse must have children, and must claim the Canada Child Tax Benefit to receive the supplement. The supplement will increase the weekly benefits to which the recipient is entitled, but not beyond the $457 weekly maximum.\textsuperscript{24}

\textit{The CCB and the Division of Powers}

The introduction of the CCB through the federal EI regime presents a dilemma with respect to the division of powers between the federal and provincial governments. The Federal Government has jurisdiction over unemployment insurance, as stipulated by section 91(2A) of the \textit{Constitution Act, 1867} (the \textit{“Constitution”}).\textsuperscript{25} A constitutional amendment in 1940 led to the inclusion of section 91(2A), to give Parliament authority over a national program of unemployment insurance.\textsuperscript{26} However, the EI regime does not address the provision of leave from employment, as this is a matter within provincial jurisdiction under section 92(13) of the \textit{Constitution}, which confers authority to the provinces for ‘property and civil rights,’ or section 92(16), which gives provinces jurisdiction to legislation on matters of a purely local nature. Therefore, for benefit programs offered through the federal EI program to be effective, provinces must enact a period of protected leave in their employment standards legislation in order for employees to take advantage of the benefits offered through the \textit{EI Act}.

\textsuperscript{21} \textit{Ibid}, s. 23.1(4)(b)(ii).
\textsuperscript{22} \textit{Ibid}, s. 14.
\textsuperscript{24} Service Canada, “Employment Insurance (EI) and the family supplement” online: Service Canada <http://www.servicecanada.gc.ca/eng/ei/service/family_supplement.shtml>.
\textsuperscript{26} \textit{Constitution Act, 1940} (U.K.), George VI 3 & 4, c.36.
Constitutionality Affirmed

The Quebec Government challenged parliament’s jurisdiction to use the EI Act to deliver maternity and parental benefits, stating that such programs are welfare or social security matters within the jurisdiction of the provinces. In January 2004, The Quebec Court of Appeal agreed with the Quebec Government that the maternity and parental leave benefits, in sections 22 and 23 of the EI Act, infringe on provincial jurisdiction over property and civil rights, section 92(13) of the Constitution, or matters of a purely local nature, section 92(16) of the Constitution. Justice Benoit, speaking for the Court, held that, “the benefits contemplated in sections 22 and 23 of the EI Act are welfare or social security measures incorporated into an insurance plan,” which come within provincial and not federal jurisdiction, under either section 92(13) or 92(16) of the Constitution. Furthermore, the Court found that Parliament had exceeded its jurisdiction over unemployment insurance, granted by section 91(2A) of the Constitution, by adding maternity and parental benefits to the EI regime. The Federal Government appealed the decision to the Supreme Court of Canada.

The Supreme Court of Canada overturned the decision of the Quebec Court of Appeal. The reasons of the Supreme Court, delivered in a unanimous judgment by Justice Deschamps, stated that the primary purpose of maternity and parental benefits is to replace lost employment income, within the jurisdiction of the federal government pursuant to their power over unemployment insurance. The inclusion of maternity benefits in the 1970’s rather than when unemployment insurance was first introduced in the 1940’s, reflected the changing nature of the labour market, in particular, the increasing prevalence of women in the work force. The Court acknowledged the secondary effects of maternity benefits, including enabling women to recover physiologically from pregnancy and childbirth and to care for their

28 Ibid.
31 Ibid, at para. 23.
families for longer than they might otherwise be able to without an income support system.\(^{32}\) However, the Court found that, in pith and substance, maternity benefits were an income replacement tool rather than a regime designed to ensure women could care for their families and recover from childbirth.\(^{33}\) The Court further held that the Attorney General of Quebec’s argument that maternity benefits are primarily a social program designed to assist families could not be sustained in light of the fact that maternity leave and job security are not dealt with by the *EI Act* and instead fall within provincial jurisdiction.\(^{34}\) Finally, the Court held that parental benefits, available to adoptive parents of both genders, ought to be characterized in the same manner as maternity benefits, that is, as a means to replace lost income when a new child arrives.\(^{35}\)

Reacting to the Quebec Court of Appeal’s earlier decision that such benefits were unconstitutional, the Quebec Government established a provincial regime governing both benefits and leave protection, which came into effect in 2006.\(^{36}\) The Quebec Parental Insurance Program, like the *EI Act*’s parental and maternity benefit provisions, is an income replacement regime. In addition to maternity and parental benefits, exclusive paternity benefits are available, as is an adoption benefit. Benefits are paid to both salaried and self-employed workers, and can be up to 75 percent of the maximum weekly insurable earnings.\(^{37}\)

**Employment Protection**

This section reviews provincial employment standards legislation, and demonstrates the difficulty of pairing provincial and federal regulation of caregiver leaves and

---

\(^{32}\) *Ibid*, at para. 29.

\(^{33}\) *Ibid*, at para 35.

\(^{34}\) *Ibid*, at para. 67.

\(^{35}\) *Ibid*, at para. 73.


50
benefits. The inconsistency across provinces, and the inconsistency between provincial leave protection and eligibility for the CCB means that there are caregivers recognized federally as being entitled to leave the workforce for a period of time to provide care, but who are not recognized provincially and are not entitled to a protected leave from employment. This review also shows that Alberta is the only province that has not introduced any form of employment protection for caregivers. Unless an employee is governed by federal employment standards legislation or is part of a union, she may be eligible for the CCB but cannot make use of it, unless her employer consents to her absence from work.

As with maternity and parental benefits, job protection and a statutory leave provision for caregivers are provided through provincial legislation rather than through the EI Act. This section will review the statutory schemes applicable across Canada governing statutory employment protection.

Since the introduction of the CCB in 2004, all provinces and territories in Canada, with the exception of Alberta, have made amendments to their provincial employment standards legislation to enable a CCB recipient to take a protected leave from her employment in order to provide care. There are variations between provinces in relation to eligibility for the protected leave and the criteria are not always the same as those applicable to the CCB, meaning an employee may be eligible for the benefit but not the leave, or vice versa. It is also important to remember that unionized employees are governed by the terms of their collective agreements rather than provincial employment standards legislation, and such collective agreements may include protected leaves from employment for employees to provide care. In addition, federally regulated employees lie outside the jurisdiction of provincial employment standards legislation, including employees of the federal government and those working in federally regulated industries, such as chartered banks or broadcasting. The Canada Labour Code, applicable to federally regulated employees across the country, defines a family member by making reference to the provision of the EI Act that defines family member, ensuring that those who are
eligible for the CCB will also be eligible for a protected eight-week leave of absence from work.\(^{38}\)

In both Quebec and Saskatchewan, the leave pre-existed the implementation of the CCB and both cover employee absences to care for relatives who have suffered a serious accident or injury or are otherwise seriously ill.\(^{39}\) Following the implementation of the CCB, Saskatchewan amended the \textit{Labour Standards Act} to extend the duration of the leave to twelve weeks per year, or for so long as the employee is receiving the CCB, which could be up to sixteen weeks per year. Quebec law permits employees to be absent from work to care for the ‘mortal illness’ of a minor child for up to 104 weeks, or two years. Otherwise, employees in Quebec may take up to twelve weeks to care for a relative who suffers from a serious accident or injury or is otherwise seriously ill. Both provinces define family members narrowly, reflecting the initial definition used in the \textit{EI Act}. Notably excluded are grandchildren, aunts, uncles, nephews, nieces, siblings or step-siblings, and the parents of an employee’s spouse are excluded by the Saskatchewan legislation. Nether province provides a leave of absence to an employee caring for a person whom the employee considers to be like a close relative.\(^{40}\)

Nunavut, the Northwest Territories and the Yukon Territory’s employment standards legislation all map the \textit{EI Act}’s definition of family member, and provide an eight-week period of leave to eligible employees.\(^{41}\) British Columbia, Manitoba, Ontario and Nova Scotia have nearly identical definitions of family member as the \textit{EI Act}. Of these four jurisdictions, all but Manitoba exclude from the definition of family member a current or former ward of the employee’s spouse and all four provinces exclude the siblings or step-siblings in law of the employee’s spouse from the definition. All four include in the definition of family member a person whom the

\(^{38}\textit{Canada Labour Code},\text{ R.S.C. 1985, c. L-2, s. 206.3.}\)

\(^{39}\textit{An Act respecting labour},\text{ R.S.Q. c.N-1.1, s. 79.8; Labour Standards Act, R.S.S. 1978, s. 44.2.}\)

\(^{40}\textit{Ibid.}\)

\(^{41}\textit{Labour Standards Act, R.S.N.W.T. 1988, c. L-1, as duplicated for Nunavut by s. 29 of the Nunavut Act, S.C. 1993, c. 28, s. 39.1; Employment Standards Act, S.N.W.T. 2007, c.13, s. 1; Employment Standards Act, R.S.Y. 2002, c.72, s. 60.}\)
employee considers to be like a close relative, and all three provide for an eight-week leave to obtain the CCB.42

Prince Edward Island, Newfoundland and Labrador, and New Brunswick’s employment standards legislation all have more limited definitions of family member than the EI Act, consistent with the definition of family member initially introduced in the EI Act in 2004, prior to the 2006 amendment. As a result, all three provinces exclude aunts, uncles, nephews and nieces, and Newfoundland and Labrador and Prince Edward Island exclude siblings, grandparents and grandchildren. New Brunswick is the only of the three provinces to include a person whom the employee considers to be like a close relative in the definition of family member.43 A comprehensive table detailing the definitions of family member is included in Appendix “A” to this thesis.

Current Use of the Benefit

This section uses information obtained from Service Canada pursuant to an access to information request to determine the up-take of the CCB from its inception to the end of September 2009. Information used in this section was obtained from Service Canada in October 2009. A copy of the correspondence with Service Canada is included as Appendix "B" to this thesis. Evaluating the actual use of the benefit is helpful in determining whether the benefit’s aims have been achieved or not, and whether those who require the benefit the most can make use of it. This section is limited to a review of the use of the benefit, and a more comprehensive evaluation will follow in Chapter 4.

By way of general introduction to the up-take of the CCB, from its inception in 2004 until the end of September 2009, just under $50 million has been paid to Canadians

42 Employment Standards Act, R.S.B.C. 1996, c. E-113, s. 52.1; Compassionate Care Leave Regulation, B.C. Reg. 281/2006, s. 1-2; Employment Standards Code, C.C.S.M. c. E-110, s. 59.2; Employment Standards Regulation, Man. Reg. 6/2007, s. 22; Employment Standards Act, 2000, S.O. 2000, c. 42, as am. by S.O. 2004, c.1, s.3, s. 49.1; Employment Standards Regulation, O. Reg. 476/06; Labour Standards Code, R.S.N.S. 1989, c.246, s. 60(E); General Labour Standards Code Regulations, N.S. Reg. 298/90, s. 7(c)(2).
43 Employment Standards Act, R.S.P.E.I. 1988, c. E-6.2, s. 22.3; Labour Standards Act, R.S.N.L. 1990, c. L-2, s. 43.14; Employee Standards Act, S.N.B. 1982, c.E-7.2, s. 44.024.
through the benefit. Slightly over 71 percent of claims are allowed, with the number of claimants increasing steadily since 2004 from 5,587 (71 percent of which were allowed), to 7,483 in 2008 (70 percent of which were allowed). The amount of benefits paid likewise increased, from nearly $7 million in 2004, to just over $10 million in 2008. The following sections detail the specific aspects of the benefit’s uptake: age and gender of recipients, duration of benefits and provincial differences in benefit up-take.

**Age**

Claimants of the CCB are concentrated in the 25-54 year age range. Since 2004, just under 43 percent of new claimants were in the 25-44 year age range and just under 36 percent were in the 44-55 year age range. Nearly 20 percent were over the age of 55 and only two percent were under the age of 25. These numbers have remained consistent across the five years of the benefit’s availability with slight increases in the percentage of new claimants being over the age of 55.

**Gender**

Since 2004, the gender breakdown of recipients of the CCB has remained constant, with an average of 74 percent of new claimants being women and the remaining 26 percent being men. There was no data indicating the gender breakdown as it relates to whether claims are accepted or denied. Figure 1, below, shows the number of CCB applicants from the beginning of 2004 until the end of 2008, broken down by gender.
A notable gender discrepancy exists between the average weekly benefits paid to CCB recipients. Between 2004 and 2008, the average weekly benefit paid to women was $312 while the average weekly benefit paid to men was $364. This reflects the CCB’s benefit level representing 55 percent of the weekly earnings of the claimant, showing that the men claiming the benefit had higher weekly earnings than the women in their qualifying periods. The gender breakdown is consistent with the empirical data presented in Chapter 1, which established that approximately three-quarters of informal caregivers are women. The gendered implications of caregiving have a significant effect on policy design and implementation, as will be discussed further in Chapter 6, dealing with policy options for Canadian caregivers.

**Duration of Benefits**

The access to information request provided two different sources of information regarding the duration of benefits. One indicated that the average duration of benefits for recipients of CCB is 5.6 weeks, from the January 2004 until September 30, 2009. The other source indicated that the average duration of the benefits has consistently remained 4.7 weeks from 2004 until 2008. This second source also provided a gender breakdown of the average duration of benefits, with men receiving the benefit for an average of 4.75 weeks, and women for 4.65 weeks. There are no notable discrepancies in the duration of benefit received as broken down by age range. It is
also important to consider that all the claimants who received the CCB served a two-week waiting period prior to receiving their benefit.

**Provincial Differences**

Using census data from 2006 and comparing it with the number of claimants for CCB from each province in the period 2004 to 2008, Alberta did not have a disproportionately low use of the CCB despite lacking provincial employment protection legislation. Alberta’s population in 2006 was 10.4 percent of the Canadian population, and 9.5 percent of new claims for the CCB were from Alberta. On the other hand, the same evaluation revealed that Quebec’s use of the CCB compared to its population was disproportionately low. Quebec’s population in 2006 represented 24 percent of the country’s population, but only 16.7 percent of all new claims came from Quebec. Ontario and British Columbia both had a difference of about 3 percent between the proportion of their population and the proportion of CCB recipients in the same period. Figure 2, below, shows the proportional population of each province in relation to the national population, and indicates the percentage of CCB claims from each province as a proportion of all claims.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Newfoundland and Labrador</td>
<td>1.60</td>
<td>278</td>
<td>1.30</td>
<td>0.30</td>
</tr>
<tr>
<td>Prince Edward Island</td>
<td>0.43</td>
<td>129</td>
<td>0.60</td>
<td>(0.17)</td>
</tr>
<tr>
<td>Nova Scotia</td>
<td>2.89</td>
<td>792</td>
<td>3.71</td>
<td>(0.82)</td>
</tr>
<tr>
<td>New Brunswick</td>
<td>2.31</td>
<td>559</td>
<td>2.62</td>
<td>(0.31)</td>
</tr>
<tr>
<td>Quebec</td>
<td>23.87</td>
<td>3554</td>
<td>16.65</td>
<td>7.22</td>
</tr>
</tbody>
</table>

Evaluating the actual use of the CCB shows how the benefit is not used equally across the population, with notable gender and regional disparities in usage.

**Federal Income Tax Credits**

There are three federal income tax deductions available to reduce the financial strain of caregivers targeted directly to the caregiver: the caregiver credit, the infirm dependent deduction and the eligible dependent deduction. A personal disability credit and a medical expense credit are also available, both of which can be transferred from the dependant to a care provider in the same family given certain conditions.

The caregiver credit is a non-refundable tax credit, meaning it must offset other taxable income earned by the taxpayer. To be eligible, the taxpayer must maintain a home where a dependent lives. To be considered a dependent for the purposes of the credit, the person must be a designated family member over the age of 18 and de-

---

46 *Ibid*, ss. 118.2, 118.3(1).
dependent on the taxpayer due to a physical or mental impairment. A designated family member over the age of 65, whether they are actually dependent on the taxpayer or not, is also considered a dependent for the purposes of this credit. A taxpayer is not eligible to claim this credit for the care of a spouse or common-law partner, though the class of family members for whom the benefit can be claimed is broad and includes the child, grandchild, parent, grandparent, brother, sister, niece or nephew of the taxpayer or of the spouse or common-law partner of the taxpayer. Unlike the CCB, the credit cannot be claimed in respect of a person whom the taxpayer considers to be ‘like family’.

The value of the caregiver credit was $630 in 2009, but it varies slightly from year to year, with an increase to $633 in 2010. As the credit is non-refundable, taxpaying caregivers must have a taxable income that exceeds the amount of the other credits for which they are eligible in a given year, including the personal credit. The credit is means-tested against the income of the dependant. A dependant with an income of over $14,336 in 2009 will have her caregiver’s benefit reduced by 15 cents per dollar over that amount, meaning a dependant with an income over $18,536 will make their caregiver ineligible for the benefit.

A taxpayer can also claim an infirm dependent deduction, which, like the caregiver credit, can be claimed in respect of a dependent adult who need not live with the taxpayer. The relationship between the dependent and the taxpayer must fit the same criteria as those for the caregiver credit. A taxpayer is not entitled to claim the caregiver credit and the infirm dependent deduction in respect of the same person, regardless of which family member uses the caregiver credit. The distinction between the infirm dependent deduction and the caregiver credit is that the taxpayer can claim the former with respect to individuals who are completely dependant on either the taxpayer alone, or the taxpayer along with other people. The value of the

47 Ibid, s. 118(1)(c.1)(ii).
49 Ibid.
50 ITA, supra note 45, s. 118(1)(d).
infirm dependent deduction in 2010 is the same as the caregiver credit, at $633.\textsuperscript{51} Like the caregiver credit, the deduction is reduced when the care recipient’s annual income exceeds $5,992, and is unavailable when the care recipient’s income reaches $10,215.\textsuperscript{52}

A taxpaying caregiver can also claim the eligible dependent deduction in addition to either the infirm dependent deduction or the caregiver credit.\textsuperscript{53} This deduction is restricted to a taxpayer who is either not married or in a common law relationship, or if she is, she is not living with, supporting, or being supported by her partner. In order to claim either the infirm dependent deduction or the caregiver credit, the taxpaying caregiver must have been the only person to have claimed an eligible dependent deduction in respect of the dependant person, even though the deduction can be split between more than one person providing support. Like the infirm dependent deduction and the caregiver credit, the taxpayer must have a familial relationship with the dependant for whom she claims the eligible dependent deduction, and like the caregiver credit, the dependant must have lived with the taxpayer in a home maintained by the taxpayer in the given year. In 2010, the value of this deduction is $1,557.\textsuperscript{54}

The personal disability credit can be transferred to a caregiver who is eligible for the infirm dependent deduction or a caregiver credit in respect of the same person.\textsuperscript{55} The transfer requires that the individual to whom the credit is owed had no income in the given tax year. Like the infirm dependent deduction, the taxpayer need not be the sole provider of care or resources to the dependant, and the amount can be split between care providers.\textsuperscript{56} The value of the deduction varies annually, but in 2009 was $1,079.\textsuperscript{57} In 2008, the federal government announced that it would implement income splitting amongst spouses where one spouse earned no income in order to

\textsuperscript{51}“2010 Tax Credits – Basic Amounts” online: TaxTips <http://www.taxtips.ca/nrcredits/nrcredits2010base.htm>, [“Tax Credit Table”].

\textsuperscript{52}Ibid.

\textsuperscript{53}ITA, supra note 45, s. 118(1)(b).

\textsuperscript{54}Tax Credit Table, supra note 51.

\textsuperscript{55}ITA, supra note 45, s. 118.3(1).

\textsuperscript{56}Ibid.

\textsuperscript{57}Tax Credit Table, supra note 51.
care for one or more members of their family who was disabled. This policy has yet to be implemented.

The medical expense credit allows a deduction for eligible medical expenses, which are broadly defined and need not have been incurred in Canada. This credit is refundable when it is claimed by the person for whom the expense was incurred, or their spouse or minor child. However, it is limited to a maximum of $10,000 when it is transferred to a family member who is also claiming the person for whom the expense was incurred as a dependant. The credit may be transferred to more than one supporting person, and each person may claim up to the maximum amount, increasing the value of the credit.

Provincial Income Tax

Each province except Quebec has a provincial caregiver credit and infirm dependent and eligible dependent deductions mirroring the federal deductions in eligibility. The amounts vary for each credit, and for each province, the amount of the care-giver credit is reduced if the dependent’s income reaches a certain level, and is eliminated entirely when the dependent’s credits ranges from the lowest in Nunavut, at $169 for 2010 to the highest in Alberta at $974 for 2010. The thresholds on the dependent’s income for a reduction in the credit’s value range from $12,156 in Newfoundland and Labrador to $15,486 in Alberta, and are eliminated when the dependent’s income exceeds $14,339 in PEI, to $25,225 in Alberta. The value of the infirm dependent deduction also varies between provinces, from $162 in Nunavut to $974 in Alberta,
with the same reduction and cut-off thresholds as the caregiver credits. The eligible dependent deduction varies from the lowest, at $383 in Ontario, to the highest, at $1,683 in Alberta.

Like the federal caregiver tax credit, the dependent and the taxpayer must live in the same residence for both the caregiver credit and the eligible dependent deductions. Also, like the federal caregiver tax credit, the taxpayer need not provide care to the dependent, so the credit reflects instead a social policy encouraging elderly or dependent individuals to reside with their family members.

Quebec offers a refundable caregiver tax credit, the value for 2010 being $1,057. A taxpayer may claim this credit for more than one dependent. Additionally, Quebec recently introduced a credit for respite providers. The credit is distributed by the primary caregiver to volunteer respite providers who have provided over 400 hours of respite over the course of a tax year. Each volunteer may receive a credit of up to $500, with the total that the caregiver may allocate being capped at $1,000. A refundable credit is also available to caregivers who hire professional respite services, and 30 percent of the cost of these services are eligible, up to $1,560.

Manitoba recently introduced a primary caregiver tax credit in addition to the non-refundable caregiver tax credit available in that province. The credit is fully refundable, and available to caregivers whether they live with the dependant or not, and the caregiver and recipient need not be related. The value of the credit is $1,020, and the caregiver may claim it up to three times in a tax year for three different care recipients for whom they are providing care. The care recipient must meet certain requirements for care as defined by the Manitoba Home Care Program. The caregiver must not be otherwise be paid for the care work they provide. There is a

---

65 Ibid.
66 Ibid.
67 Taxation Act, R.S.Q. I-3, art. 1029.8.61.61 – 1029.8.61.70.
68 Ibid, art. 1029.8.61.71 – 1029.8.61.75.
69 Ibid, art. 1020.8.61.76 – 1029.8.61.82.
70 Manitoba ITA, supra note 62, as am. by S.M. 2008, c. 3, s. 25 and S.M. 2009, c. 26, s. 22.
three-month qualifying period prior to the caregiver being eligible for the credit, and an application is required.\(^{71}\)

**Nova Scotia Caregiver Allowance**

In 2009, Nova Scotia’s Department of Health, Continuing Care Branch instituted a caregiver allowance program, the first of its kind in Canada. The introductory policy document announcing the new program states that the allowance is “provided to Eligible Caregivers to acknowledge their contributions in providing assistance to a family member or friend and to assist the caregiver in sustaining the support they provide.”\(^{72}\)

The allowance is modest at $400 per month and is means-tested against the income of the dependant requiring care. To be eligible, a caregiver must be at least 19 years old and a resident in the province. The caregiver must be in a “regular, ongoing care giving relationship with the person receiving care,” and must provide at least 20 hours per week of assistance.\(^{73}\) The care relationship must be expected to continue for more than 90 days and is re-evaluated on an annual basis. The care recipient must also meet eligibility requirements, including an assessment by a continuing care coordinator, and a finding of “a very high level of functional impairment.” The net income of the care recipient must be less than $18,785 if single, or a total net household income of less than $35,570.\(^{74}\) The caregiver must not be otherwise paid for their provision of care, and must sign an agreement defining the terms and conditions of the allowance program.\(^{75}\)

---

\(^{71}\) *Ibid.*, s. 5.11.


\(^{75}\) *Ibid.*
Conclusion

This chapter explored the current legislative framework that forms the basis of caregiving policy in Canada. The first part of this chapter explored the CCB, in particular the eligibility requirements for the benefit. This was followed by a discussion of the 2006 Supreme Court of Canada decision affirming the constitutionality of similar benefits offered through the *EI Act*. The chapter then looked at the various provincial employment standards legislation governing protected leaves from work to provide care. It noted that regional disparity exists within Canada, showing that the benefit is not accessible equally across the country. Finally, the actual use of the CCB was explored using information obtained in an access to information request. This confirmed regional disparities in uptake of the benefit, and also highlighted the gendered up-take, which mirrors the empirical evidence in Chapter 1 showing that three-quarters of caregivers are women. The up-take data, along with the evaluation of the provincial employment standards legislation and an understanding of the CCB eligibility criteria, will form the basis of the evaluation of Canada’s policy support for caregivers.

The second part of this chapter reviewed ancillary income support measures provided to Canadian caregivers. Three different federal credits may help caregivers reduce their tax burden, however because they are non-refundable, they apply only to caregivers who are otherwise earning a taxable income. Quebec and Manitoba are both unique in that they have introduced refundable credits for caregivers. Quebec, in particular, offers tax credits to assist caregivers offset the costs associated with respite care, and rewards volunteer respite services through a tax credit. Finally, the means tested caregiver allowance in Nova Scotia was discussed, as the only program of its kind in Canada. The next chapter evaluates these income support measures in light of the theoretical approaches advanced in Chapter 2.
Chapter 4: Evaluating Canada’s Support for Caregiving

This chapter will evaluate current Canadian policies supporting caregivers, as discussed in the previous chapter. The discussion in Chapter 2 as to the theoretical orientations on care, will guide this evaluation. In particular, current policies will be evaluated with a view to whether they are consistent with an ethics of care orientation, or whether they run against such an orientation.

The first part of this chapter gives a brief overview of the home care options in three Canadian provinces, to provide a basis from which to understand the demand for informal caregivers. The chapter then evaluates at the Compassionate Care Benefit (the “CCB”), in particular, the gendered implications of delivering the CCB through an employment related regime. Finally, the income tax provisions discussed in the previous chapter will be evaluated. This chapter will demonstrate that the current policies supporting caregivers are not adequately reflective of an ethics of care orientation, and the policy options discussed in Chapter 6 will use this evaluation as a basis for designing and re-modeling care policy in Canada.

Home Care Options in Canada

Extended health care services, including home care, do not fall within the purview of the Canada Health Act (the “CHA”). As a result, responsibility for providing such care falls to the provinces. The CHA requires provinces to provide medically necessary services to Canadian residents free of charge. More specifically, the CHA requires provinces to provide, through their provincial health insurance system, “insured health services” on a universal and accessible basis, and defines such services as hospital or physician services. The CHA also defines “extended health

---

1 Canada Health Act, R.S.C. 1985, c. C-6, [“CHA”].
2 Ibid, s. 9.
3 Ibid, s. 10.
4 Ibid, s. 2.
care services” as including “home care service.”⁵ There is no requirement in the CHA that extended health care services be provided through the provincial health insurance program.

A review of the home care policies in three provinces will show the extent to which provincial governments provide support to dependants who are not institutionalized, thereby lessening their reliance on family members for support. Although the focus in this section is on dependants living in private homes and the programs aimed at assisting them, informal caregivers also play a role when dependents are institutionalized.

**Nova Scotia**

Nova Scotia has a provincially funded home care program to provide long-term care to those who require it. The services include nursing care and home support, the former including intravenous therapy and catheter care, and the latter including light housekeeping and personal care. Respite care is also provided to relieve a primary caregiver for a period of time. A care coordinator from the Department of Health’s Continuing Care Department assesses prospective clients to determine their needs and assess their means. The same coordinator is responsible for determining when a client ought to be placed in a long-term care facility.⁶

Nursing and palliative care services provided through the home care program are free to the dependant. Home care services are provided free of charge to approximately 80 percent of clients, with the remainder paying approximately $10 per hour, to a stipulated monthly maximum. Determining the monthly maximum payment by a patient, or whether services are provided free of charge, is means-tested based on both income and household size. The home care services offered publicly in Nova Scotia are intended to supplement but not replace care provided by family and

---

community. As mentioned in Chapter 3, Nova Scotia is the only Canadian province with a caregiver allowance. The means-tested allowance of $400 per month is available to care providers of low-income residents.

Quebec

Home support services in Quebec are organized through community service centres ("CLSC’s"). Like other provinces, Quebec encourages home care rather than institutionalization for patients who have a safe home where they can live and so long as they choose to stay at home.8

The CLSC organizes home support services based on a professional needs assessment of two areas, the patient’s ability to perform domestic activities and their ability to perform activities of daily living. Publicly funded home support is provided to all eligible patients and includes professional care and services, such as medical or nursing services. Also included are home assistance services and services for caregivers including respite services. A patient with the inability to perform activities of daily living as well as domestic activities will also receive support in the form of domestic and personal hygiene assistance. However, a patient who is unable to perform domestic tasks but is capable of taking care of their activities of daily living will qualify for publicly funded home support only if they are considered low-income. One-fifth of the 87 percent of Quebec seniors living in a conventional home have a moderate or severe disability requiring assistance in activities of daily living and domestic life, and studies indicate that between 70 and 85 percent of their support is provided by informal caregivers who are families or friends.9

Quebec is the only province with universal prescription drug insurance for residents.10 The cost of prescriptions is not fully insured, but contributions may be waived based on the income level of the patient or their family. Any Quebec resident

7 Ibid.
9 Ibid.
10 An Act respecting prescription drug insurance, R.S.Q. c. A-29.01.
under the age of 65 who is eligible for a private plan through their own employment or that of a family member must enroll in the private plan; otherwise they must enroll in the public plan. Those 65 or older are automatically eligible for the public plan but may instead maintain private insurance so long as it is equivalent in coverage to the public plan. 11

As mentioned in the previous chapter, Quebec has recently introduced unique provincial income tax credits for caregivers. Quebec also has a low up-take of the CCB on a proportional level compared with the rest of Canada, but evaluating the home care and long-term care policies in Quebec did not reveal that there is a greater degree of publicly provided care that would explain a lesser need for informal caregivers. This may mean that the reason for the lower uptake amongst those in Quebec is related to eligibility rather than need for the benefit.

**Ontario**

Ontario provides home care services organized through Community Care Access Centres, with fourteen such centres around the province under the governance of the provincial Ministry of Health and Long-Term Care. Patients are assessed by their local centre and a determination is made as to their need for home care services. These services may be provided free of charge to eligible patients and can include visiting health professional services, personal care and support and homemaking. The centres are also responsible for assessing the eligibility of patients for residence in a long-term care facility. Eligibility for government funding or subsidies is means-tested with regards to the care receiver’s income, or the income of the care receiver’s family. 12

As with the other provinces, details about the income cut-offs for means tested services in Ontario is not readily available, either in legislations or regulations. What

---

12 “Senior’s Care: Arranging Care” online: Ontario Ministry of Health and Long-Term Care <www.health.gov.on.ca/english/public/program/ltc/18_care_mn.html>.
is standard across the three provinces evaluated is that home care services to promote the ongoing independence of a frail elderly or ailing person are provided by the state only as a complement to the informal work expected of the family. Indeed, the entire family’s income is often the basis of evaluation for the means-tested provision of benefits.

This section has provided a brief overview of how home care services are delivered in three provinces, to demonstrate that the home care and long-term care policies of provincial governments rely heavily on the informal care work of families and offer state funded services only where the dependent cannot make arrangements for their own care through a combination of family care and care services purchased in the market. Provincial funding for home and long-term care target low-income care recipients, or care-recipients living in low-income families.

The Compassionate Care Benefit

The first policy to evaluate is the CCB, and using the data obtained from the access to information request, this section will evaluate how the CCB operates in light of the theoretical perspective advanced in Chapter 2. Both the delivery mechanism and the eligibility criteria will be examined to determine whether they support or undermine an ethics of care approach to caregiver support. A study released in March 2010 by Allison Williams and her colleagues evaluated the CCB from the perspective of family caregivers (the "CCB Report").

This research provides helpful guidance in the evaluation of the CCB as it relies on first-person data from family caregivers who were both successful and unsuccessful applicants for the benefit as well as those who did not apply for the benefit.

---

13 Allison Williams, et al., “Evaluating Canada’s Compassionate Care Benefit: From the Perspective of Family Caregivers” (Hamilton, Ont.: School of Geography and Earth Sciences, 2010), online: Canadian Caregiver Coalition <http://www.ccc-cccan.ca/media.php?mid=287>, [“CCB Report”].
**Delivery Mechanism**

Using the *EI Act* to deliver the CCB arises from the use of the act to deliver first, maternity, and then parental benefits to Canadians. The justification, as Justice Deschamps discussed in *Reference re. Employment Insurance Act ss. 22 and 23*, is that the benefit replaces income lost due to absence from the workforce for the arrival of a child, or in the case of the CCB, for the care of a dying relative.\(^\text{14}\) Thus, maternity and parental, and by extension, the CCB, are not primarily tools of social or family policy, but instead an insurance scheme to cushion income losses incurred by workers.

The relatively recent introduction of the CCB has garnered little academic attention or evaluation. However, there is a great deal of literature about the delivery of maternity and parental benefits through the *EI Act*, and many of the themes addressed by this literature can be extended to evaluate the use of the *EI Act* as a means of benefit delivery for the CCB.

It is important to consider the advantages of using the *EI Act* as a means of benefit delivery: it is the only way the federal government can constitutionally give a benefit that would otherwise likely be characterized as one within the purview of provincial governance. The constitutional amendment in 1940 permitting the federal government to develop a national unemployment insurance scheme persists today as one of the only ways that the federal government directly delivers benefits to Canadians; others being the federal pension program, and the old age security pension and guaranteed income supplement.\(^\text{15}\) Benefits are indirectly delivered by the federal government through the federal income tax system as well. The provincial authority over property and civil rights dictates that provinces are empowered to deliver social benefits to their constituents. The benefit of a federally organized system is that it ensures equality for members of society across the country in terms of entitlement to benefits. The drawback, from the perspective of constitutional

\(^{15}\) *Constitution Act, 1940* (U.K.), George VI 3 & 4, c.36.
division of powers, is that a federal program has less flexibility and responsiveness to the needs or demographics of a particular province. Indeed, the social and labour policies differ by province, and to that end, provincially managed benefit schemes could be tailored to these differences and be more efficient and useful. The concern, of course, with provinces assuming responsibility is the concern that a particular province simply will not adopt a benefit scheme. This will be discussed further below, in Chapter 6, considering policy options for Canada.

One of the positive aspects of the CCB, as Rachel Cox points out in her analysis of maternity and parental benefits, is that it constitutes a rights-based benefit rather than a need-based benefit. Need-based benefits can stigmatize recipients, and as she points out, there is a tendency for recipients to be subject to, “arbitrary moral judgments about their ‘dependence.’”\(^\text{16}\) In the context of maternity and parental benefits, the rights-based approach may be preferable to a need-based approach because it alleviates stigmatization associated with dependence on social benefits and is universally accessible to those who are eligible without regard to their need for the benefit. However, as will be discussed further in the next section, eligibility for the CCB is difficult and produces gendered results. The attachment of benefits to employment can be problematic from the standpoint of aspiring to a ‘Universal Caregiver’ model as posited by Nancy Fraser, because it renders employment and market participation the norm and care work as an exceptional circumstance against which to be insured. Attaching social benefits to employment reflects a caregiver parity model of social policy, which aims to make care cost-less by replacing market earnings for care workers; rather than influencing a paradigm shift wherein care is taken more seriously.\(^\text{17}\)


Eligibility for the CCB

The main concern with the use of the EI Act as a means of delivering the CCB is its accessibility. Eligibility, discussed in detail in Chapter 3, can be difficult, making benefits offered through the regime inaccessible. In particular, the CCB is predominantly used by women, and women are much less likely than men to be eligible for benefits pursuant to the EI Act generally, and the benefit specifically, on the basis of hours of insurable earnings in the qualifying period. Although the access to information request did not provide details as to the gender breakdown of denied applicants, it was clear from the information that roughly three-quarters of successful applicants are women. Though there is no literature on the specific issue of women’s eligibility for the CCB, a number of writers, and in particular, feminist writers and organizations, have criticized the exclusionary nature of the employment insurance (“EI”) eligibility requirements for maternity and parental benefits. Reviewing their work is helpful because many of the eligibility criteria for the CCB are the same as for the benefits they have evaluated.18

The first problem is entitlement to the benefit on the basis of insurable earnings. As discussed in Chapter 3, an applicant must have 600 hours of insurable earnings in their qualifying period, usually the preceding year. Prior to 1996 amendments to the EI Act, eligibility for maternity and parental benefits was determined on the basis of weeks worked, rather than hours. The 1996 amendments reduced eligibility for both men and women, but this had a disproportionate effect on women’s eligibility for both regular benefits as well as parental and maternity benefits. Prior to the amendments, 53 percent of men and 49 percent of women who were unemployed were eligible for regular EI benefits. By 2001, these numbers shrunk to 44 percent of men being eligible and only 33 percent of women being eligible, a drop of 11 percent for men and 16 percent for women.19

19 Cox, supra note 16, at 5; this number has remained constant to 2009: Canadian Labour Congress, “Statement by the Canadian Labour Congress to the House of Commons Standing Committee Regarding the Status of Women Study on the Consequences and Effects the Current Employment
week for an entire year are ineligible on the basis of these new eligibility rules; and even women who work more than 11.5 hours per week but only work part of the year may have difficulty qualifying. As Cox points out,

[T]he employment insurance program has evolved around the model of a traditional male worker with a stable- full time, year-round job, who doesn’t have to interrupt his work to take care of other people, as if often the case for women workers.20

Cox also states that women are more likely than men to work in jobs that do not conform to the traditional full-time, year-round model.21 She also points out that the eligibility requirements are even more exclusionary for those who are marginalized on account of their race, culture or disability or immigrant status.22 The unpaid work of women in the home, whether the care of children or other dependents, directly impacts their eligibility for maternity and parental benefits, and for regular EI benefits.

### Application Process

One of the findings of the CCB Report was that the application process for the CCB was at times confusing and time-consuming.23 One of the recommendations of the CCB Report was to simplify the application process and ensuring benefit delivery is faster. Recipients of the benefit wait the two-week unpaid waiting period, but their first payment may not be until four weeks later, causing financial strain. Finally, applicants for the benefit reported being in an exhausted, stressed, and vulnerable position at the time of their application. Consistent with this finding is the

---

21 Ibid.
22 Ibid.
recommendation of the CCB Report to ensure the application process is "more sensitive to the stressful and emotional realities of CCB applicants." 24

Amount of Benefits

The next problematic aspect of the CCB, particularly for women, is the value of the benefit received. As with maternity and parental benefits, a successful applicant will receive 55 percent of her insurable earnings, but her earnings are calculated on the basis of her earnings for the 26 weeks immediately preceding the claim. For expectant mothers who intend to access the maternity or parental benefits, this may be problematic if they reduce their workforce participation due to their pregnancy. However, the problem is more acute for caregivers intending to access the CCB. Because the CCB is available only for caregivers of dependents who are within six months of death, and because the CCB is available only where the care recipient requires the care of the caregiver, it is likely that many caregivers have reduced their workforce participation for the weeks and months leading up to their application for the benefit. This significantly reduces the earnings on which the benefit is based. A further difficulty with the CCB is the requirement that the applicant’s earnings have decreased by at least 40 percent prior to their eligibility for the benefit. Whether this decrease takes the form of a pro-rated salary decrease, or fewer wage hours, the weeks during which an employee’s earnings are decreased so substantially are the same weeks on which their earnings are calculated to determine the amount of their benefit. As with maternity and parental benefits, a two-week waiting period is imposed on applicants, during which they cannot work but also cannot receive benefits. The combination of these factors makes it difficult for a caregiver to make use of the benefit, especially if she has a low income to begin with. The access to information data indicates that women are entitled to significantly less CCB than men. The average weekly benefit for men in the period between 2004 and 2008 was $364 per week, while the average for women in the same period was $312; a difference of $52 per week.

24 Ibid, at 1.
Use of an Insurance Model

Social insurance, by definition, operates as a user-funded risk allocation mechanism. Although maternity and parental events are not usually considered risks, they do jeopardize attachment to the labour force, as does care work. However, by the very nature of insuring against risk, defining care work and the arrival of children as risks suggests that they are exceptional events, and interrupt the normal course of employees. Rather than viewing these events as normal parts of a life-course, an insurance model treats them as exceptional. Such an approach to care demands does not accord with an ethics of care orientation because it does not view demands for care as a normal aspect of the human life course, an does not reflect care as a political ideal because it does little to ensure state responsibility for care. To the extent, however, that EI is user-funded by both employees and employers, some of the social costs of such life-events are subsidized. Because contributions are mandatory by those who may never use the benefits, as well as those who may use the benefits more than once, the EI Act spreads work-related ‘risks’ across all workers in a universal way.

This was especially true prior to the recent amendment to include self-employed workers who wish to access maternity, parental, sickness and compassionate care benefits. As of January 2010, any self-employed worker may opt to pay a premium to join the program, and will be entitled to the benefits after a certain period of contribution.25 To the extent that the inclusion of self-employed workers is optional, and the option is determined by the worker, this does undermine the insurance principles of the scheme. An older man who is self-employed with no foreseeable care responsibilities is unlikely to opt-in to the plan, and will "self-insure", so to speak, in the highly unlikely event that he must stop working to provide care. A young woman who anticipates having several children, on the other hand, will most likely opt-in to the program. The optional aspect of this new amendment does not spread the costs associated with insurable risks across the working population evenly.

---

and distorts the principles of insuring against risk by making it economical for only those with a high-risk of needing benefits to opt in to the program. That being said, extending maternity, parental and compassionate care benefits to the self-employed is welcomed because it increases the proportion of Canadians able to access these benefits, in particular, women who would otherwise be ineligible for special benefits.

**Other Limits to the CCB**

In addition to the eligibility limitations discussed above, and applicable to other special benefits offered through the *EI Act*, there are several aspects of the CCB in particular which limit its availability. The 2006 amendment to the *EI Act*, discussed at greater length in Chapter 3, expanded the definition of family member to whom an employee can provide care. The inclusion of a person that the employee considers ‘like family’ is a significant improvement over the formerly restrictive definition. This new definition accounts for close care relationships that may not fit the traditional familial model, and acknowledges the significance of close friends or more distant kin providing care.

The CCB requires the care recipient to be within six months of death at the time the employee makes the application for benefits. While this does provide the caregiver benefits for a period of time when care needs may be most acute, it does not take account of the duration of most care relationships, which last months or years. As established in Chapter 2, informal caregiving relationships last an average of five years. Despite this restriction, the more problematic aspect is that only six weeks of benefits are provided to the caregiver. Although this is certainly more helpful than no benefit, the short duration, and the low value of the benefit, mean that it may not provide sufficient support to caregivers. The CCB Report concluded that caregivers applying for the benefit were troubled by this requirement, and as a result, were unsure when in the care recipient's illness progression to take the benefit. Some participants waited too long, and as a result, the care recipient died either during the application process or during the two-week waiting period, making them ineligible for any benefits. Applicants and non-applicants also reported difficulties in determining whether the care recipient was within six months of death, expressing a
desire to be with the care recipient at the very end of their life, but doctors being unable to determine the anticipated time of death to such a level of precision.\textsuperscript{26}

The failure of the CCB to adequately provide benefits to caregivers is reflected by the initial cost estimates of the program, compared with the actual expenditures of the program. In his 2002 report, \textit{The Health of Canadians - The Federal Role}, Senator Michael Kirby recommended the implementation of the CCB and estimated the costs of six weeks of employment insurance would cost $240 million dollars per year.\textsuperscript{27} The 2003 Budget Plan, which introduced the federal budget including the CCB, stated that the program was estimated to cost $86 million in 2003-2004, and $220 million for each year thereafter.\textsuperscript{28} The access to information request shows that, between 2004 and late 2009, the CCB cost the employment insurance program only $50 million dollars; representing roughly three and a half percent of the estimated cost. This indicates one of two things: either the estimates were wrong; or the target group is unable to access the benefit. Based on this review, the latter conclusion is the most likely reason for the estimated and actual costs of the CCB being so different. Given the estimated cost of the program versus its actual cost, expanding the value of the benefit by increasing its duration, or increasing the percentage of the insurable earnings provided, or both, represent reasonable options. Another way to increase access to the benefit is to loosen the eligibility requirements, including the minimum insurable hours threshold and the requirement of death within six months. More caregivers would be able to access the benefit if those requirements were altered. Reform options for the CCB will be further discussed in Chapter 6.

\textsuperscript{26} CCB Report \textit{supra} note 13, at 8.
\textsuperscript{28} Department of Finance, Canada, “The Budget Plan, 2003” (Ottawa: Department of Finance, 2003), online: Department of Finance <http://www.fin.gc.ca/budget03/PDF/bp2003e.pdf>, at 73.
**Regional Disparity**

Moving from the evaluation of the CCB as a whole, this section looks to the regional disparities that result across the country as a result of differing employment standards legislation. As established in Chapter 3, the main difference between provincial legislation is the differing definition of family to whom a caregiver can provide care and receive an eight-week protected leave from work. The most notable difference is that Alberta provides no employment protection to caregivers, even when the caregivers may be eligible for the CCB. However, evaluating the up-take statistics for the CCB shows that this does not disproportionately affect the proportionate up-take of the CCB in that province. This suggests that employers may be willing to agree with employees that they may take time away from work, or that the majority of caregivers in Alberta using the CCB are governed by the Federal *Canada Labour Code* or a collective agreement. Regardless of the up-take data, a province that does not provide such protection does reflect a social policy that does not adequately recognize the importance of care-giving work. A lack of recognition for caregivers is inconsistent with an ethics of care orientation because it marginalizes the work of caregivers by inadequately supporting their need to take time away from work to provide care.

Apart from Alberta, there are two approaches to employment standards across the country. Quebec and Saskatchewan both had leave provisions in their employment standards legislation pre-dating the introduction of the CCB. These provinces permit employees to leave work to care for a seriously ill relative, and there is no need for the relative to be within six months of death, as required by the CCB. Both provinces define "relative" narrowly, not mirroring the new definition in the *EI Act*, and exclude most extended relatives or those people whom the caregivers consider ‘like family’, in some ways, the legislation in these provinces extends to a wider contingent of caregivers than the CCB because there is no requirement that the care recipient is expected to die; but at the same time, the legislation does not cover all employees entitled to the CCB because of the more narrow definition of relative. Quebec is unique in providing up to two years of employment protection to employees caring
for a dying child. Income support could be obtained by caregivers of such children, but only for the six-week period provided by the CCB and only during the six-month period prior to the expected death of the child.

The territories, British Columbia, Ontario, Manitoba and Nova Scotia all have employment standards legislation that maps the CCB requirements closely, providing eight-week periods of leave to employees caring for dying relatives. Their definitions of family member vary slightly, but are nearly as broad as the current definition of the EI Act. The employment standards legislation in Prince Edward Island, Newfoundland and Labrador and New Brunswick all continue to use the definition of family member initially used for the CCB, and is therefore quite narrow. These provinces also require the care recipient to be within six months of death. The implication of the narrow family definition used in these provinces is that a caregiver could be entitled to the CCB without being entitled to a corresponding leave from employment.

This review demonstrates regional disparity across the country in terms of accessibility to the CCB. Caregivers may be entitled to the CCB but may not have a statutory right to be absent from work in their province, likely because the person to whom they provide care does not fall within the definition imposed by the legislation in their province. The disjunction between employment standards legislation and eligibility for the CCB, caused by the split jurisdiction between federal and provincial governments, makes the system unequally accessible across the country.

Uniformity as to minimum standards across the provinces in the way that leaves are provided for compassionate care reasons would be beneficial and would promote equality for caregivers across the country. In particular, provinces that do not include in their definition of family member a person whom the employee considers to be ‘like family’ removes the flexibility of the CCB. Non-traditional familial arrangements give rise to many close dependency relationships that are not otherwise

---

29 An Act respecting labour, R.S.Q. c.N-1.1, art. 79.8.
recognized by law, and the recognition of these relationships in the EI Act goes some way to protecting and recognizing caregivers in non-traditional family situations.

The uniformity of benefit availability, versus the uniformity of statutory leave provisions may also be problematic. A federally organized benefit may not have sufficient flexibility to respond to the unique situations in each province. For example, if certain provinces provide more services than others, perhaps an individual will have less use for the CCB, but instead a different type of benefit such as one that provides some compensation for a caregiver moving to part-time work. In other provinces, where the service delivery level is less, a caregiver may not be able to use the CCB at all because they have left the workforce entirely prior to their care recipient nearing death, and will not qualify for the benefit. It is important for benefits provided to caregivers are responsive to the realities faced by caregivers in each province, having regard to the level of services and the labor market conditions in those provinces.

**Tax Policy**

Canada’s federal income tax policy, mirrored for the most part by provincial tax schemes, provides modest tax credits to caregivers who otherwise earn a taxable income. The caregiver credit and the infirm dependent credit, which cannot be claimed by the same taxpayer in respect of the same person, do not require any care to be provided by the taxpayer to the dependent. The credits, then, reflect support for those who provide economic support for those over the age of 65, or people who are otherwise dependent. From the perspective of providing financial support for caregivers, Canada’s current income tax policy falls short in several ways.

First, the non-refundable nature of the credits means that they are only accessible to caregivers who otherwise have a taxable income. As discussed throughout this thesis, providing care often means that caregivers will leave the workforce or will reduce their workforce participation. To the extent that having taxable income is a pre-
requisite to using these credits, the caregiver credit and the infirm dependent deduction tie the receipt of benefits to workforce participation. Low-income caregivers with no taxable income are not able to receive any assistance from the federal tax credits. The caregivers who require financial support the most, those in low and medium income brackets, are the least likely to be able to use the tax benefits because they may not have sufficient taxable income. This approach to supporting caregivers undermines an ethics of care approach because it does no universally acknowledge or financially assist all caregivers, only some caregivers. To the extent that providing care can further financially marginalize caregivers, this tax policy exacerbates their financial strain by making benefits unavailable to them due to their low-income status. The policy also reinforces the privatization of care by ensuring caregivers without employment receive no state assistance, and entrenches the liberal paradigm of according social benefits to those who are engaged in the labour force, as only those who participate in the market are recognized by this policy.

For taxpayers with sufficient income to make use of these benefits, the value of the benefits may not be of sufficient value to offset actual costs incurred in providing care, especially because the value of the credit is reduced as the income of the dependent (rather than the caregiver) increases. A very likely example of how this could pose problems is a person over the age of 65, whether they are dependent on the taxpayer or not, draws money from their retirement savings account or earns pension payments to support themselves; but the taxpayer will be ineligible for the caregiver credit if the dependent has an income from their retirement savings or pension exceeding a certain threshold, currently $18,645.30

Another aspect of the federal income tax policy that is problematic for caregivers is the narrow definition of family. In order to be eligible for the benefit, the dependent must fit within a prescribed definition of family that excludes people the taxpayer considers ‘like family’. Many caregiving relationships are not between people who

30 “2010 Tax Credits – Basic Amounts” online: TaxTips <http://www.taxtips.ca/nrcredits/nrcredits2010base.htm>
are legally considered family, and the change to the CCB eligibility requirements reflecting this ought to be mirrored by income tax policy.

The tax initiatives in both Manitoba and Quebec to assist caregivers are welcome improvements, but create significant regional disparity in the tax treatment of caregivers across the country. The refundable nature of the credits in both provinces is an excellent feature as it ensures caregivers who need financial assistance the most will receive it. It also creates a guaranteed income for caregivers who are not working. Neither province makes eligibility for the credit dependent on the low income of the care receiver, ensuring greater access to financial support.

**Regional Disparity**

There are significant differences in the tax treatment of caregivers across the country, with caregivers in Manitoba and Quebec eligible for refundable tax credits in addition to federal and provincial non-refundable credits. The use of refundable credits, albeit modest in value, ensures that low income is not a bar to the use of the credit. This is particularly important for caregivers, the target of the credit, because the very nature of their care work demands reduced employment income and some will even have no income. This leaves the most financially vulnerable caregivers without any benefit from the tax system. Caregivers in other provinces, however, are not eligible for any similar provincial tax credits, and the amount of the tax credit offered to caregivers differs between provinces. Another variation between provincial tax regimes is the income threshold of the dependent at which point the caregiver is no longer entitled to the credit. To the extent that these differing amounts reflect the specific needs of the province, slight variation in amounts may not be problematic. It is noteworthy that Alberta offers the highest provincial caregiver credit, and the highest ceiling on dependant’s income before the caregiver is ineligible for the benefit.
Conclusion

The first section of this chapter gave a brief overview of the home care options in three Canadian provinces. This overview showed the extent of public funding for home care, and how provincial home care policies rely heavily on informal caregiving and operate as adjunct rather than a replacement to informal care. This chapter then offered a critical evaluation of the current financial support policies for Canadian caregivers, with the aim of using some of the flaws identified in current policies to introduce reforms in Chapter 6. The next chapter looks to several other countries to gain additional insight into possible policy solutions, and is followed by Chapter 6, which makes concrete policy recommendations aimed at ameliorating the position of Canadian caregivers.
Chapter 5: International Perspectives

Having evaluated Canada’s support for caregivers, I now propose to examine the approaches taken in other countries to support caregivers. This chapter will examine policies in place in Denmark, Sweden and Ireland to support informal caregivers. While it is difficult to translate policies from a different socio-political context into Canada, it is possible to consider some of the developments in other countries for inspiration and guidance for policy development in Canada. Reviewing policies in these three countries will also provide a measure of comparison to assess the strengths of Canada’s current policies.

The three countries discussed in this chapter were chosen for specific reasons. First, Sweden and Denmark are both countries that have historically provided generous social benefits to their populations. In particular, child and family-friendly policies in place in these and other Nordic countries are often cited as models for policy development internationally in particular due to the impact these policies have on increasing both fertility rates and labour force attachment. While Canada’s welfare state is not as generous as those in the Nordic countries, there are certain similarities, including universal health care and funded maternity and parental benefits. These similarities make policy translation more realistic.

Ireland was chosen because the country offers two unique legislative protections for caregivers, protecting them from discrimination in both the workplace and the provision of services. Ireland is also a helpful comparator country because it provides more conservative benefits to caregivers than those offered in Nordic countries, and the solutions may therefore represent a middle-ground for Canadian policy-makers to consider.

---

1 See for example: Anne Lise Ellingsaeter, “Leave policy in the Nordic welfare states: a ‘recipe for high employment/high fertility?’” (2009) 12 Community, Work & Family 1. While generous parental leaves are not directly related to increased fertility or labour force attachment, in combination with other social, cultural and economic factors at play in Nordic countries, they contribute to a favorable climate for both parenthood and a return to the labour market by parents.
All three countries also have similar standards of living, as indicated by similar gross national income (“GNI”), per capita, levels. This makes drawing comparisons between social policies more useful. Economic measures of GNI and purchasing power parity (“PPP”) will be discussed further in the next section.

The information relied on in this chapter comes primarily from a comprehensive pan-European study conducted between 2003 and 2005, entitled EUROFAMCARE. This international research project was conducted to provide “a European review of the situation of family carers of elderly people,” with the aim of changing social policy to promote “a partnership approach between family carers, professional providers and cared-for.” Part of the EUROFAMCARE project involved extensive background reports on 23 European countries, detailing the services provided to family caregivers, amongst other things. Relying primarily on background reports prepared for this research project is helpful, as the reports for each country address the same research questions, for the same time period, providing detailed and comparable information. These reports also have the advantage of situating the eldercare social policies within the broader socio-political context of the country, which also aids in drawing comparisons to the Canadian context.

**Economic Measures**

Another factor to consider in the comparison of the Canadian social policies with those in other countries is the cost and standard of living. A comparison of the benefits provided to caregivers in other countries must be evaluated in light of the economic situation of those caregivers. There is no single measurement that can sum up the relative worth of a given benefit in different economies, as there are simply too many variables to account for: in some countries, prescription drugs are covered by a public program funded through taxation; in other countries, a high level of social support for caregiving means that there are fewer informal caregivers, in some countries, caregiving labour is provided entirely outside the economic sphere,

---

provided entirely informally. The countries discussed in this chapter are all somewhat similar because they all have some public care funding and some benefits for informal caregivers. With the hopes of making an assessment of the relative value of benefits offered in these comparator countries, I will use two specific economic indicators to assist my comparison, GNI and PPP.

One way to measure the relative economic situation amongst countries is to compare their PPP. This measure offers a standardized way to compare the average economic situations of a country’s inhabitants by determining the cost of purchasing a given basket of goods or services in a country, using the country’s own currency, and then standardized to one currency, usually the United States (“US”) dollar, in order to permit comparisons. The PPP is more useful than, for example, the gross domestic product of a country, when the goods or services being compared are not readily trade-able on the market, and therefore are less tied to international currency exchange rates which can experience a great deal of volatility depending on many external factors.

Figures from the International Monetary Fund’s World Economic Outlook Database provide PPP measures for the countries used in this chapter. In 2005, the PPP, standardized to the US dollar, was 1.257 for Canada, 0.995 for Ireland, 8.463 for Denmark and 9.931 for Sweden. This means that, according to the PPP values, it costs 8.463 US dollars to purchase a given product in Denmark, the same product being 1.257 US dollars in Canada, 0.995 US Dollars in Ireland, and 9.931 US Dollars in Sweden. Put more simply, it costs much more to buy the same things in Denmark and Sweden as it does in Canada and Ireland. This makes comparing the value of benefits between Canada and Ireland quite easy, but much more difficult for

4 Ibid.
6 Ibid.
comparing the value of benefits between Canada and Sweden or Denmark. That being said, it is impossible to zero-in on the costs associated with a particular product or service across countries – there is no measure that indicates the relative costs of, for example, hiring a caregiver, in each of these countries. The benefit of this analysis is to demonstrate that, even though the benefits for caregivers may appear more generous in Denmark and Sweden, the relative cost of living in these countries is much higher. This may mean that the real or relative value of benefits in these countries is diminished, in comparison to the benefits offered in either Ireland or Canada.

The second economic indicator that I use to assist in my comparison is the GNI per capita converted using PPP reflected in US dollars, rather than fluctuating exchange rates. This is helpful because it is reflective of actual resources available within a household to purchase external caregiving labour, or the ability to subsidize caregiving labour within the household by supporting a family member’s absence from the labour force to instead provide care. One of the most apparent shortcomings with this measure of comparison is the degree to which there is public funding for goods or services in a given country, meaning that a household need not expend after-tax income on such goods or services. For example, a country that provides full prescription drug funding, funded through taxation, would mean that, although the taxpayer’s after-tax income is likely less, they have fewer financial obligations. The opposite, is of course, also true. To the extent that a country privatizes the market for a given good or service, and reduces taxation accordingly, a household should theoretically be able to purchase those goods and services with the increase in after tax income resulting from reduced tax rates.

The World Bank publishes annual reports of the GNI per capita based on PPP. In 2008, Canada’s GNI was $38,710 US, Denmark’s was $37,570 US, Sweden’s $37,780, and Ireland’s $35,710. This shows that Canada and each of the comparator countries have about equal GNI measures, which makes drawing comparisons

---

between them on the basis of the value of social benefits more easy. The similarity in GNI is also helpful because it situates the countries in the higher-income spectrum from a global perspective, as it is more appropriate to draw on social policy models from equally situated countries.

With this short review of both PPP and GNI in the countries discussed in this chapter, the next three sections of this chapter will evaluate the benefit programs offered to caregivers in Denmark, Sweden and Ireland. Each section will also offer a brief overview of the socio-political context of each country to offer context for their benefit programs. Throughout each section, comparisons will be made to the policies in place in Canada.

**Denmark**

The EUROFAMCARE background report for Denmark (the “Denmark Report”) details the social and political orientation of the country in order to situate the policies in place that support caregivers. The overview indicates that Denmark has a highly active labour market.\(^8\) As such, there is no “reserve of economically inactive females” who can devote themselves entirely to care work.\(^9\) A 1999 study cited in the Denmark Report found that 78-79 percent of the family caregivers in Denmark are female, a proportion similar to that in Canada.\(^10\)

Denmark’s social benefit structure is strong, with an emphasis on state provision of elder care services and a highly active labour market contributing to a tax base sufficient to support the extensive benefit regime in place.\(^11\) A universal pension is in place, and residents, whether they have participated in the labour force or not, are

---

9 Ibid, at 23.
11 Ibid, at 33.
entitled to the pension at age 65. This enables seniors to remain independent regardless of their prior labour force participation. This, along with a move away from institutionalized care for the elderly, like in Canada, results in most care provided in the home of the care of the recipient. Autonomy and independence on the part of seniors is encouraged.

Family members who wish to care for a relative may do so in lieu of state funded care. There are two programs in place to facilitate such family caregiving. First, an employed person who wants to provide care to a dependant in the home may do so if the care recipient and the local authority in charge of care provision agree to it. Furthermore, the alternative must be that the dependant would otherwise require 24-hour care outside the home, or the care required amounts to a full-time job. In such a case, the care recipient receives a subsidy from the local authority to engage the family member as a care provider and the care provider becomes an employee of the municipality providing the subsidy. However, there is no employment protection for an individual leaving the labour market to undertake care for a relative.

The second option for family care provision in Denmark is where a terminally ill care recipient wishes to die at home and be cared for by a relative. An employed person may take an absence from her job to provide care, with the assurance that her employment is protected. Furthermore, compensation for lost wages is provided, as the employer is required to continue paying the employee during their absence, but is then reimbursed by the state for the duration of the absence at the rate of 1.5 times the sickness benefit to which the employee is entitled. In the case of a person who is self-employed or otherwise not entitled to the constant care allowance provided to an

12 Ibid, at 29.
13 Ibid.
15 Ibid.
16 Denmark Report, supra note 8, at 33-34; CSSA, supra note 14, s. 119-122.
employee, the state provides the amount of 11,609 Danish Krones per month, equivalent to $2,471.56 Canadian per month.\textsuperscript{17}

While the Denmark Report did not provide a figure representing the cost of these two programs to the Danish economy, in 2002, it was estimated that approximately 30.5 billion Danish Krones were spent on care for the elderly.\textsuperscript{18} This equals roughly $6.5 billion Canadian. The Danish population being approximately 5.4 million people in 2005, is about one sixth of Canada’s population of 31.6 million in the same year.\textsuperscript{19} It follows that adopting a similar model of eldercare in Canada may conceivably cost just under $40 billion Canadian per year. This extrapolation of cost ought to be considered tentative, considering the extensive social programs available to Danish elders, not specifically elders with terminal illness or highly dependant elders.

Furthermore, the labour market participation and taxation rates in Denmark differ from those in Canada, making this estimate highly contingent. With a higher rate of labour force participation in Denmark than Canada and a higher tax rate, Denmark brings in more money through taxation, per person, than Canada, resulting in more resources available for publicly funded services.

The evaluation of support for family care providers in Denmark shows that the country is prepared to shoulder the economic costs associated with both elder care generally, including the care of terminally ill and highly dependant frail elderly. Options for employed family members who wish to provide care are available to Danes, and the programs discussed ensure that little economic sacrifice on the part of the employed care provider is expected. Furthermore, the Danish approach does not unduly burden employers by requiring any employer contribution to leaves taken by care providers. The two systems discussed above operate to ensure that care provided by a family member will not be undertaken for the reason that “no one else is

\begin{footnotesize}
\begin{enumerate}
\item \textit{Ibid}; Canada Revenue Agency, “Average Exchange Rates for 2009”, online: Canada Revenue Agency <http://www.cra-arc.gc.ca/E/pub/tg/rc4152/rc4152-lp-09e.pdf>, [“Rate Conversion”]. The average exchange rate in 2009 was 0.2129 Danish Krone for $1 Canadian.
\item Denmark Report, \textit{supra} 8, at 60.
\end{enumerate}
\end{footnotesize}
available to do it,” a rationale provided by half the care providers in Canada. As a result, the ability to care as a “labour of love” is maintained in Danish society.

**Sweden**

Like Denmark, Sweden has robust social support programs and emphasizes economic re-distribution amongst the population. However, from the late 1990’s to 2005, a marked increase in informal caregiving was reported in Sweden, from about 30 percent of the population reporting caregiving responsibilities for elders with whom they did not cohabit to over 50 percent in 2005. The same study concluded that the percentage of Swedes providing informal care within their own homes remained stable at about five percent. One reason for this increase may be cutbacks to the welfare state, resulting in care ‘substitution’: care that was previously provided formally must now be provided informally.

Comprehensive social service legislation at the national level makes special provision for both elderly and functionally impaired Swedes, entitling them to care and assistance as required. There are also three programs targeting informal caregivers. Care provision is the responsibility of the municipality in Sweden, financed primarily through local taxation.

The first program is a non-taxable attendance allowance. This is a payment made by the municipality to the dependant, intended to be paid to the care provider. The maximum amount of this payment is about 5000 Swedish Krona per month.

---

equivalent to approximately $747 Canadian.\textsuperscript{25} Eligibility is based on the extent of the care recipient’s dependency and need for caregiving.\textsuperscript{26}

The second program is a carer allowance. This is a payment from the municipality to the care provider, reimbursing the care provider for their work at the same rate as formal home help employed by the municipality. A care provider must be under the national retirement age of 65 years to receive this payment. The value of the payment varies, with the maximum being about 14,000 Swedish Krona per month, equivalent to $2,090 Canadian.\textsuperscript{27}

Finally, a care provider who is also working is entitled to a 60-day leave from employment to care for a terminally ill relative. The job protection is also funded, providing the employee with 80 percent of her wage financed through the National Social Insurance scheme.\textsuperscript{28}

The Swedish approach to supporting caregivers is similar to the Danish approach, with the bulk of financial responsibility for caregiving falling on the state. The policies in place in Sweden also reflect autonomy and choice on the part of both caregivers and care recipients. The payment of the attendant allowance to the care recipient, for example, permits the care recipient to exercise a degree of choice in determining who provides her care. The protections afforded to caregivers of terminally ill relatives are very similar to the Compassionate Care Benefit (“CCB”) in Canada, with a slightly longer duration and a greater degree of funding. This program also has consistency between the absence from work and the funding, unlike in Canada where eligibility for the CCB and obtaining a leave of absence from work are governed by separate jurisdictions. To the extent that employed Swedes are able to rely on the state to provide necessary care to their family members, this policy

\textsuperscript{25} Sweden Report, supra note 20, at 35; Rate Conversion, supra note 17. The average exchange rate for 2009 was 0.1493 Swedish Krona to $1 Canadian.
\textsuperscript{26} Sweden Report supra note 20, at 35.
\textsuperscript{27} Sweden Report, supra note 20, at 35; Rate Conversion, supra note 17. The average exchange rate for 2009 was 0.1493 Swedish Krona to $1 Canadian.
\textsuperscript{28} Sweden Report, supra note 20, at 35.
likely reflects the fact that fewer Swedes than Canadians bear the primary responsibility for care to their family members.

**Ireland**

Unlike the Nordic countries discussed above, Ireland does not have the same history of extensive social benefits, and home and community care are residual in nature, falling on the state only where there is no informal care provider to provide services to the dependent.\(^{29}\) Also, unlike the Nordic countries, female involvement in the labour market lags at only 50 percent, making half of Irish women available for unpaid care work.\(^{30}\) It is estimated that between 5 and 6 percent of the adult population in Ireland provides informal care, with approximately 60 percent of caregiving provided by women.\(^{31}\) Like Canada, several factors are leading to increased attention to informal care provision: more women are entering the work force, increased geographic dispersion of families, and a reduced focus on the obligatory nature of women’s care work.\(^{32}\)

There are several tax benefits available to care providers in Ireland, including the Home Carer’s Tax Credit, though it is noted that the financial relief provided by this benefit is minimal.\(^{33}\) Tax relief is also provided for costs associated with employing a caregiving in the home, and a benefit for costs associated with nursing home care, which could provide a financial incentive for families to institutionalize care recipients rather than provide care themselves.\(^{34}\)

Aside from the tax benefits that may be available to informal caregivers in Ireland, there are two benefits to provide income support: the Carer’s Benefit and the Carer’s

---


\(^{30}\) *Ibid*, at 7.

\(^{31}\) *Ibid*, at 15-16.

\(^{32}\) *Ibid*, at 29.

\(^{33}\) *Ibid*, at 17.

\(^{34}\) *Ibid*. 

92
Allowance. Ireland also has two pieces of legislation which protect caregivers from discrimination on the basis of their status as a care provider, which will be addressed following the discussion of the two financial benefits.

The Carer’s Benefit is provided through social insurance, and is provided to individuals who leave the work force temporarily to provide care. The benefit is available for up to 65 weeks for each care recipient. Caring for one person entitles the care provider to 139.70 Euros per week, the equivalent of $221.49 Canadian. The amount increases by 70 Euros per week if care is provided to more than one person. This benefit is like the CCB in Canada as it is dependant on previous labour market participation, and is limited in duration, although provided for a much longer period of time. A Carer’s Leave is provided by statute to protect the employment of the care provider for up to 65 weeks. This operates in the same way as provincial employment standards legislation in Canada.

The Carer’s Allowance is provided through the social insurance legislation to caregivers without regard to their previous labour market participation. It is a means-tested allowance, providing 129.50 Euros per week, the equivalent of $205.32 Canadian. The amount is increased by 18.30 Euros per week if the caregiver is over the aged 66 or older. In the event of care being provided to more than one recipient, the amount of the allowance increases to 194.40 Euros per week, or $308.22 Canadian, which is also increased for caregivers aged 66 or older, to 221.70 Euros per week, the equivalent of 351.50 Canadian dollars per week. As the allowance is means-tested, these values represent the maximum benefits available. The means-

---

36 Ireland Report, supra note 29, at 70; Rate Conversion, supra note 17, the average exchange rate in 2009 was 1.5855 Euro for $1 Canadian.
38 SWCA, supra note 35, s. 179-186; Ireland Report, supra note 29, at 71.
39 Ibid.
testing is against the income of the household as a whole, not specifically the income of either the caregiver or the care recipient.40

According to a consultation study with caregivers in Ireland, most caregivers felt that the level of benefits offered by the Carer’s Benefit and the Carer’s Allowance were insufficient and that they inadequately reflected the value of care work they perform. In addition, the means-testing requirements were criticized by those who were ineligible for benefits as an indication that their care was worth less than care provided by those receiving the benefits, because it went without compensation.41 A study evaluating caregivers for dementia patients in Ireland concluded that the monetary relief offered by these programs is insufficient.42 Caregivers would rather be paid for their work directly, preferably by the state.43 The same study concluded that informal care is viewed by the state as a ‘free resource,’ and the current benefits operate as an income maintenance program, rather than compensation for caregiving.44 The study advanced support for a universal ‘Continual Care Payment,’ which would be provided to caregivers on the basis of the dependencies of the care recipient, without regard to the means of the caregiver or the care recipient.45

In addition to financial benefits offered to Caregivers, Ireland has two statutes that explicitly recognize caregivers, the Employment Equality Act, 1998 and the Equal Status Act, 2000.46 Both statutes prohibit discrimination on the basis of one’s family status, including one’s status as a primary care provider to a dependant. The Employment Equality Act, 1998 prohibits discrimination in the employment of caregivers, and the Equal Status Act, 2000 prohibits discrimination in the provision of

40 Ireland Report, supra note 29, at 71.
42 Eamon O’Shea, “Costs and Consequences for the Carers of People with Dementia in Ireland” (2003) 2 Dementia 201, at 216.
43 Ibid, at 213.
44 Ibid, at 216.
45 Ibid.
publicly available goods and services to caregivers, not unlike human rights legislation in Canada.

Analysis

This section will offer a brief analysis of the social policies discussed above, and compare the policies with those in Canada.

Based on their history of family-friendly social policies, it is not surprising that both Sweden and Denmark offer comprehensive financial support to caregivers who choose to provide care to family members. The review also demonstrated that these two countries place primary responsibility for caregiving on the state, and as such, employed family members have the option not to be primary caregivers. The policy instruments used in Denmark and Sweden, namely, direct financial payments to either the caregiver or the care recipient, have only recently been introduced in the Canadian context, by way of the Caregiver Allowance program in Nova Scotia. However, several aspects of the policies discussed are not ideal. In Denmark, no employment protection is provided to individuals who leave the labour market to care for relatives, unless the relative is terminally ill. As well, the employment protection offered in Sweden is of limited duration at only 60 days, though the funding for such a leave is more generous than that offered by the CCB, at 80 percent of the caregiver’s wage. Other than taxing some of the direct financial compensation, neither country offers any financial benefits to caregivers through their income tax policy, unlike in Canada. This reflects an approach that does not premise the value or availability of financial benefits on a caregiver’s income or labour force participation. However, given the higher labour force participation in these countries than in Canada, and the view that care responsibilities fall primarily on the state rather than on individuals, tying benefits to labour force attachment is less significant and less problematic in these countries as the exclusionary effects would be less prominent than in Canada.
In light of the PPP and GNI measures discussed earlier in this chapter, the degree of financial assistance offered to caregivers in Sweden and Denmark may not be as generous as they first appear when simply converting the value into Canadian dollars. As the PPP measures indicate, things cost relatively more in Sweden and Denmark – about eight times as much, even though the GNI measures for these countries are similar to those in Canada. This significantly reduces the actual value of the benefits to caregivers on a relative basis. The review of these two countries indicates that caregiving in Sweden and Denmark is often a choice for members of society because of the robust public funding of care services, and despite services costing relatively more, fewer people may have to actually expend money on caregiving, either by paying for the labour of a caregiver or paying the costs associated with caregiving such as for prescription drugs or necessary medical devices.

Ireland, on the other hand, has policies in relation to caregiving that come closer to the current policies in Canada. Comparing Ireland and Canada, from an economic point of view, is made easier by the near equal PPP and GNI measures in each country, indicating that goods and services cost relatively the same amount in both countries. As noted earlier in this chapter, however, there is no indication of the relative costs of care-related services in either country, so a more precise comparison is not possible. As for the policy instruments used in Ireland, like Canada, they use general income tax policy to effect social policy by providing tax benefits to care providers, and to help offset costs associated with hiring private care. However, much like Canada, it is observed that such measures are of minimal benefit, and caregivers feel entitled to more benefits. Like Canada, in Ireland, being a caregiver may not be a choice for people, the way it is more likely to be in Sweden or Denmark. As such, caregivers may depend more heavily on financial assistance from the state in order to maintain financial security during their time as caregivers.

One of the most significant findings in this review was the use in Ireland of anti-discrimination legislation to protect caregivers. Such legislative action signals an active recognition of the significance of care work to society, and the fact that many caregivers may be adversely affected in the workplace because of their status as a
caretaker. Along with other ideas explored in this chapter, the use of anti-discrimination legislation will be considered in the next chapter, which will develop policy recommendations for Canada.

**Conclusion**

This chapter reviewed the social policies in place in Denmark, Ireland and Sweden to both compare the policies supporting caregivers with those in Canada, and to generate new ideas for Canadian policy. At the outset of the chapter, the difficulties of comparing the value of benefits in different countries was outlined, and the measure of PPP was discussed as a way to more effectively make comparisons of the relative monetary value of financial benefits. The review of policies in these three comparator countries revealed that, although there is room for improvement in Canada’s social policy, our country offers comparable benefits to caregivers. Some of the ideas presented in this chapter will be used to make recommendations for policy reform in the next chapter, including increasing the duration of protected leaves of absence from work to provide care and enhancing human rights protection for caregivers in provincial and federal law.
Chapter 6: Policy Options for Canada

This chapter draws on the discussion from all preceding chapters to develop concrete policy solutions to further support caregivers in Canada. The solutions proposed by this chapter are intended to be incremental steps to reform, rather than wholesale solutions to the problems faced by caregivers.

The first section will discuss the importance of considering gender in policy. It will also recall some of the theoretical perspectives advanced in Chapter 2, in order to situate the proposed solutions in the broader framework of analysis for this thesis. This section will also advance two considerations to guide policy development, the first being the importance of national consistency as to a minimum level of benefits and the second being the consideration of caregiver characteristics rather than premising benefit entitlements solely on the characteristics of the care recipient.

The second section proposes policy changes intended to remedy the long-term financial instability faced by caregivers as a result of their decreased labour force participation. These proposals include amending the drop-out provisions of the Canada Pension Plan (the "CPP") and changing the contribution rules for registered retirement savings plans ("RRSP") to enable caregivers to generate contribution room during the period they are caregiving, with decreased or no earnings, in order to encourage private old-age savings with a more flexible investment structure.

The third section of this chapter addresses more direct and immediate policy changes that would help alleviate financial instability on the part of caregivers. This includes recommendations to amend the Income Tax Act (the "ITA") to make federal and provincial caregiver tax credits refundable, and increasing the value of the credits.

Another policy recommendation is to introduce caregiver allowance programs on a national level, like the program in Nova Scotia. This will include a discussion of

---

1 Canada Pension Plan, R.S.C. 1985, c. C-8, [“CPP”].
2 Income Tax Act, R.S.C. 1985, c. 1 (5th Supp.), [“ITA”].
whether such an allowance program ought to be universal or means-tested, concluding that a universal program is the most desirable way to implement a caregiver allowance. This section then offers recommendations for improving the Compassionate Care Benefit (the "CCB") to enhance eligibility and up-take of the benefit. In particular, making the CCB more responsive to the actual characteristics of caregivers and caregiving relationships by extending the duration of the benefit and eliminating the necessity of the expected death of the care recipient will make this benefit much more compatible with actual caregiver experiences.

The fourth section of this chapter will look at non-pecuniary aids to caregivers that would complement the policy options for financial aid. Training and respite are highlighted in this section as particularly important.

Finally, the fifth section of this chapter briefly touches on two options that would indirectly benefit caregivers, as a result of directly benefitting care recipients. The first is the inclusion of all palliative care services within the mandate of the Canada Health Act (the "CHA"); and the second is the introduction of mandatory national prescription drug insurance.

Framework for Policy Development

This first section considers four aspects that will influence policy developments discussed in the later sections of this chapter. Each of these aspects will be discussed in turn.

Considering Gender

The significant proportion of caregiving performed by women requires a policy framework that is uniquely responsive to the needs of women. As the SWC Report discussed in Chapter 1 noted, evaluating policy through a gender lens is important because, "of the ubiquitous nature of gender differences in the social context in which

3 Canada Health Act, R.S.C. 1985, c. C-6, ["CHA"].
we live, specifically in elder care." In particular, the gendered effects of social policies have a significant effect on policies aimed at ameliorating the financial strains of caregivers. Other authors have concluded that women are generally excluded from the policy making process in Canada, and specifically, that policy decisions resulting in the reduction in home care services in Ontario were not publicly considered or debated. With this in mind, this chapter focuses on reforms to current policies affecting caregivers, with a view to incorporating ideas advanced in Chapter 2 of this thesis about an ethics of care, and the gendered effects of policy more generally.

**An Ethics of Care**

Chapter 2 reviewed the works of Joan Tronto, Mona Harrington and Nancy Fraser to provide a theoretical orientation from which to develop and reform Canada’s current caregiver policies. Tronto and Harrington’s work advanced the idea of using an ethics of care approach to make care a political ideal. This is accomplished by being mindful of the universal and inherent nature of care in our lives, and acknowledging that dependence is a condition faced by everyone during some times in their life course. Ensuring that the work ethic, and the neo-liberal model of social member as worker do not mask important care work is a primary goal for these theorists. Both Tronto and Harrington believe that adopting care as a political ideal will enhance the democratic participation of caregivers, who have traditionally been excluded from the policy process.

---


To this end, developing policies that support caregivers in a meaningful way can hopefully aid their entry into the policy process by giving them the recognition and support required to expend energy on expressing their voices for positive change. However, at the outset of this chapter, I note that much of the work that has attempted to give a voice to caregivers to this point has failed to adequately inform the political process of the significance of care work. There are also relatively few studies that examine in a qualitative way the experiences of caregivers so as to provide an empirical foundation for policy development. This leaves a gap, between quantitative evidence about who provides care and how much; and the policies that are developed with the aim of supporting caregivers. As a final note to this introductory section, I comment that increasing this type of qualitative work to learn more about the experiences of caregivers is a necessary step to achieving the goals set out by Tronto and Harrington, to engage caregivers as democratic members of society in the policy development process. The few works that provide such rich qualitative detail about the experiences of caregivers have been invaluable in developing this chapter, and to the extent that any policy recommendations contained herein receive broader political attention, some of the goals that Tronto and Harrington have for this type of work have been met, and hopefully more work in this area will lead to greater strides in policy development.

**National Consistency**

One of the most apparent failings of the current policies governing support for caregivers is the inconsistency across provinces and the lack of a minimum standard for benefits. While there is a need to ensure that policies reflect regional differences, it is also important to ensure that caregivers are treated equally across the country, in terms of the availability of benefits. This is difficult due to the provincial responsibility for most of the policies impacting caregivers, however given the federal government’s responsibility for health care, there is an opportunity to develop

---

national consistency through funding guidelines. Some of the suggestions in this chapter require provincial action for implementation, namely a prescription drug insurance program and changes to employment standards legislation and provincial income tax legislation.

Other suggestions require federal action, including changes to federal income tax policy or amendments to the Employment Insurance Act (the “EI Act”). Many of these suggestions require coordinated action between both levels of government to be effective. Changes to the CCB will not be useful unless provincial employment standards legislation is amended to be consistent with the eligibility requirements of the benefit. Changes to provincial income tax legislation to mirror federal income tax legislation in terms of eligibility for credits or deductions ensures a consistent and integrated taxation policy. Cooperation between the two levels of government, then, is one of the prerequisites to implementing comprehensive policy changes to assist Canadian caregivers.

One of the most prominent examples of federal-provincial cooperation is health care. Federally funded but provincially administered, the universal health care system relies on conditional funding from the federal government to compel the provinces to administer health care according to federal policy demands. The CHA ties health care funding to the provinces with a set of principles by which the provinces must administer their health care programs, including most notably universality and comprehensiveness. One way to bring some of the changes discussed in this chapter into place is to integrate them into the CHA. Universal palliative care has been recommended by a number of policy makers, and by specifying this in the CHA, provinces would be required to provide such care to residents as a condition of the Canada Health Transfer payment. Other recommendations, namely those relating to employment standards, cannot so easily be tied to federal funding, and will require

---

9 Department of Finance, “Canada Health Transfer” online: Department of Finance Canada <http://www.fin.gc.ca/fedprov/cht-eng.asp >.
more innovative solutions and will on the part of the provinces to cooperate with the federal government to support caregivers.

**Caregiver Characteristics**

The programs currently in place focus on the characteristics of the care recipient alone, or on the relationship between the caregiver and the care recipient. For example, the tax benefits discussed are available to caregivers only if the care recipient’s income is below a given threshold. The availability of the compassionate care benefit depends on the care recipient’s anticipated death.

Focusing on the characteristics of the care recipient is certainly important in considering the services provided to the care recipient, but is much less relevant when assessing the needs of the caregiver. To the extent that the caregivers needs may be independent of whether the care recipient is expected to die, for example, benefit for caregivers ought to consider the needs of the caregiver. This focus will ensure that caregivers are not denied access to benefits they may require due to characteristics of the care recipient. Eligibility for home care services or respite services are based on the needs assessment conducted in relation to the care recipient. Because these services are designed to assist the caregiver and the care recipient, the needs of both ought to be considered. In particular, considering whether the caregiver is herself physically impaired, has other care responsibilities, or is employed in the market are important considerations when determining the level of services to be provided.¹⁰

This section has offered four important considerations to guide the policy options presented in this chapter. Keeping these considerations in mind, the next section turns to policies that will advance the long-term financial security of caregivers.

---

Long-Term Financial Support

The empirical evidence discussed in Chapter 2 suggests that one significant source of financial instability for caregivers is the impact of their departure from the workforce on their long-term earnings. A corollary of this impact is their ability to ensure sufficient savings, either in the form of a public pension, or through private RRSP or pension, to support their old age. Increasing caregiver’s abilities to save privately for the long-term has the added benefit of future reductions on public spending for these individuals when they are no longer working due to old age. Two mechanisms will be proposed in this section, one in relation to contributions to the public pension system and the other in relation to private retirement savings.

Pension Credits

The CPP is a social insurance scheme that is funded by contributions from Canadians during their working years. Benefits are payable to those who have contributed in the event of retirement or disability, and to survivors of contributors who die, notably, their spouse, common-law partner or dependant children. The value of benefits earned by a contributor is directly related to how many pension credits she has accrued during her time in the labor market. Contributions are based on earnings, with more credits accruing to higher earning individuals. On retirement, a contributor is entitled to an annual pension equal to twenty-five percent of her average earnings, to an annual maximum of about $10,000.11

One of the long-term costs incurred by many caregivers is reduced employment, and therefore, a reduction in contributions to the CPP. The result is that the long-term benefits accruing to caregivers are reduced, and as a result, achieving long-term financial stability is more difficult for caregivers.

The CPP includes a drop-out provision for contributors who take time out of paid work to raise children. This provision acknowledges that raising children often

results in taking time away from paid employment, thereby reducing earning and lowering the amount of pension to which the person will ultimately be entitled to receive. The child-rearing provision allows the contributor to exclude from her total earnings a seven-year period following the birth of her child.\textsuperscript{12}

No equivalent provision exists for a caregiver who reduces her employment in order to provide care, with the consequence that the value of her ultimate pension benefit is reduced. There is a general provision that permits the fifteen-percent of a contributor’s lowest earning years to be dropped from the calculation period that determines her pension entitlement. For contributors over the age of 65, low earning years occurring after the age of 65 are excluded from the calculation period.\textsuperscript{13}

A number of policy reports recommend amending the CPP to include a provision like the child-rearing provision for caregivers who reduce their work obligations to provide care.\textsuperscript{14} There may be several ways to implement such a policy, but the most appealing option is to mirror the child-rearing provision and exclude a certain number of low-earning months or years from the contributor’s calculation period, to ensure their ultimate pension entitlement is not adversely affected by the time taken away from work to provide care. Like the child-rearing drop-out provision currently in place, imposing a maximum drop-out period would ensure the system’s overall economic integrity by ensuring that extremely lengthy departures from the workforce, or years of reduced earnings, do not unjustly entitle a contributor to a disproportionately high pension.

Of the countries surveyed in Chapter 5, the pension system in Sweden is the only one to provide pension credits to caregivers. Caregivers who take a carer’s leave or receive a carer’s allowance are entitled to receive pension credits for the period

\begin{footnotesize}
\begin{enumerate}
\item \textsuperscript{12} CPP, \textit{ibid}; Pension Document, \textit{ibid}, at 7.
\item \textsuperscript{13} CPP, \textit{ibid}; Pension Document, \textit{ibid}, at 18.
\end{enumerate}
\end{footnotesize}
during which they are on the leave or taking the allowance. The costs associated with a drop-out provision would be incurred on a long-term basis, and would not be evident until current caregivers who avail themselves of the benefit are eligible for their pension.

RRSP

A reduced contribution to the CPP is aggravated by a reduction in the availability of contribution room for a caregiver’s RRSP. Many Canadians, in addition to relying on the public pension system which provides only modest benefits, ensure a more comfortable old age by availing themselves of generous provisions in the ITA that enable tax deferred savings which can then be withdrawn on the taxpayer’s retirement. The amount that an individual can contribute in a given year depends on her earnings for the previous tax year, and a year with no earnings will not entitle the taxpayer to put any money into her RRSP the following year. It stands to reason that if a taxpayer has not earned any money in a given year, she will be unlikely to have money to set aside for retirement. However, provisions in the ITA permit unused contribution room to be carried forward indefinitely.

Changing the rules for RRSP contributions in a way that permits a certain amount of contribution room to accrue to taxpayers during time out of the workforce would permit these taxpayers to make a greater contribution to their retirement when they return to the workforce, or in the event of a windfall such as an inheritance received from a care recipient on their death. This change could be extended to parents taking time out of the workforce to care for children, which would maintain consistency in the tax treatment of all caregivers, including caregivers of children. This policy change would address the long-term financial strain faced by caregivers, and encourage private savings by caregivers to reduce their need for significant publicly funded social assistance in their retirement. Furthermore, the costs associated with

16 ITA, supra note 2, at 148.
17 Ibid.
implementing such a change would be minimal, because it operates as a tax-deferral mechanism. The federal government will collect taxes on the money in the RRSP when the contributor takes the money out. This is a cost-effective solution, albeit somewhat limited in application to higher-earning caregivers, who can afford to make contributions to their RRSP. This solution may also be one of the more politically palatable solutions in the current political climate, with the Federal Conservative party considering changes to both public and private pension schemes as well as RRSP rules in the face of growing doubts about Canadian’s ability to privately save for their own retirements.\textsuperscript{18}

**Immediate Financial Support**

The preceding section focused on two ways to help caregivers mitigate the long-term financial consequences of caregiving. This section looks at policy proposals that will offer more immediate financial assistance to caregivers, through tax policy, allowances and employment related benefits.

*Income Tax Policy*

The tax credits and deductions applicable to caregivers, as discussed above, have been shown to be of little economic benefit to caregivers.\textsuperscript{19} This is for two reasons. First, the monetary value of the credits is modest. Claiming either the caregiver or the infirm dependent deduction and the eligible dependent deduction will provide a credit of $2,187. However, in order to qualify for the eligible dependent deduction, also known as the spousal equivalent deduction, a caregiver must be neither married nor in a common law relationship. Adding provincial credits from the province with the most generous credits, Alberta, adds another $974 for either the caregiver credit or the infirm dependent deduction. The spousal equivalent credit is another $1,638 in Alberta. These credits drop significantly in Nunavut, where the eligible dependent

---

\textsuperscript{18} Bill Curry, “Harper to ask Canadians for input on pension reform” *The Globe and Mail* (9 March 2010).

deduction is valued at $469 and the infirm dependent deduction and caregiver credit are each $169. Combining the most generous possible credits, that is, from both the Federal system and Alberta, and assuming the eligible dependent deduction is available, a taxpayer may be eligible for up to $4,795.²⁰ However, the means-testing applied to the dependent in these situations means that a taxpayer entitled to these credits will be entirely financially responsible for the dependent.

These credits are not reflective of the cost of supporting another individual, let alone an individual with medical condition. To the extent that the care receiver is entitled to transferrable credits that the caregiver may use, this can mitigate the costs to the caregiver. However, this premises caregiver relief on the characteristics of the care recipient without actual regard to the expenditures borne by the caregiver.

The second major flaw with the tax credits aimed at caregivers is that the income ceilings applicable to the benefits are low, and benefit only caregivers of low-income care recipients, rather than all caregivers.²¹ Means-testing the credits against the care recipients’ income limits the accessibility of the credits to caregivers who are members of a family classified as low-income. Being in a low-income family, the caregiver may not even be able to access the credits because she may have no taxable income.

The next problematic aspect of the federal tax credits is that they are non-refundable. This means that a caregiver with no income for a given year, due perhaps to the fact that they have stopped working to provide care, or are retired, will not be able to benefit from the benefit. Providing a refundable credit to caregivers could alleviate this problem, as has been implemented in both Quebec and Manitoba. Likewise, the credits and deductions available to the care recipient are non-refundable, and therefore unavailable to care recipients with no earnings in a given year. It is not difficult to imagine that a care recipient would be unable to work due to the condition that gives rise to her need for care.

²¹SWC Report, supra note 4, at 49; Caledon Policy Report, supra note 10, at 35-36.
There are several ways to improve the current tax system to benefit caregivers. First, the value of the credits could be increased to provide caregivers with meaningful financial relief. The discrepancies between the values of provincial tax credits ought to be examined with regard to the cost of living in each jurisdiction, to ensure that the tax treatment of caregivers is more equal across the country.

Next, the caregiver credit and the infirm dependent deduction should not be means-tested against the income of the dependent. This makes caregiver support too contingent on the financial position of the care recipient, whether the caregiver benefits from the income of the care recipient or not. These credits should both be universally available without regard to income, to reflect a social policy that takes caregiving seriously and recognizes the inherent value of care work.

Like Quebec and Manitoba, the caregiver credit and infirm dependent deduction should be refundable. The exclusion of low-earning caregivers from financial benefits does not reflect an equitable or supportive caregiver policy. This also further marginalizes caregivers who do not work, but may have insufficient income to support themselves and their care recipients. Introducing ancillary tax benefits, such as the Quebec respite benefits, would be beneficial additions to both federal and other provincial tax systems. These benefits reflect the dependencies of the caregiver themselves, and the support of the state directly aimed at helping these caregivers take care of their own physical and mental well-being. Like Québec, these credits need not be sufficiently high to act as compensation for a respite provider, but rather, a token of recognition and appreciation for the work of volunteer respite providers. Although full compensation would be preferable, a token of recognition is a first step to establishing a program of full compensation, and may be more feasible due to the lower cost.

One final consideration for changes to tax policy is the finding, established in Chapter 1, that a majority of caregivers incur travel costs in relation to their caregiving. This suggests that the majority of care relationships do not occur within one household, at least perhaps at the outset of the relationship. By making changes to current benefits,
or introducing new benefits, that accommodate caregiving relationships in separate households would likely have a beneficial impact on most caregivers. In particular, such a benefit would directly recognize and support the caregiving relationship, rather than supporting, as current income tax policy does, economic dependence.

**Direct Financial Compensation**

All three countries surveyed in the international review of caregiver policies in the previous chapter provide direct financial compensation to caregivers or care recipients. Nova Scotia recently introduced a caregiver allowance of $400 per month, a unique development in Canada.\(^{22}\) Introducing direct financial compensation for caregivers, either by providing it directly to an eligible caregiver, or to the care recipient to use as payment for the caregiver, presents several challenges. These challenges include setting the level of compensation, determining whether it would act as full compensation to a care provider at the same rate as obtaining care in the market, and to whom it would be paid, the caregiver or the care recipient.

In 2003, Sheri White and Janice Keefe prepared a briefing report on the issue of financial compensation for caregivers, in conjunction with the Canadian Caregiver Coalition.\(^ {23}\) The report highlighted some of the difficult questions to address in considering such a program. They first identified the two primary forms of payment as either salary or wages to reimburse for the care hours provided, or allowances which are not directly to the hours of care work. According to the authors, allowances are more common internationally, and they are, "considered to be a financial contribution to caregiving situation rather than compensating caregiver directly for the time involved."\(^ {24}\) The report also reviews payments to caregivers

---


\(^{24}\) *Ibid*, at 2.
provided in other countries, including Australia, Norway, Sweden and the United Kingdom.\textsuperscript{25}

The goal of providing direct financial assistance to caregivers is to maintain the relationship between the caregiver and the care recipient, and delays institutionalization of the care recipient. These programs are not viewed as a replacement of family support systems but instead complement it. Such a program may be beneficial in Canada because it could cause caregivers to access home care and other community sport services earlier, since typically they are accessed too late. This is because caregivers, knowing of the financial assistance available, will seek out the financial assistance and in the course of doing so, will be connected with other social services.\textsuperscript{26} Payments could also ensure that caregivers maintain greater control and flexibility over the caregiving situation, because the payments could enable the caregiver to work less or hire respite services when needed.

Furthermore, in order to be meaningful and helpful to caregivers, financial compensation will have to reflect the costs of living of the caregiver to a certain extent. While a higher earning caregiver may be more readily able to absorb the costs associated with weeks or months away from the workforce, they may have significantly more financial obligations than a lower earning caregiver. Factors including whether the caregiver has children or other dependants ought to be considered in evaluating appropriate levels of compensation. Likewise, there are variations across the country, and even within provinces, in the cost of living. A federal or even provincial plan to provide compensation will have to look at these variations and set compensation levels accordingly. Ensuring such programs are available across the country, and share a minimum standard, will ensure national consistency in the availability and type of benefits for caregivers.

Whether direct financial compensation ought to be means-tested is another concern with introducing this type of benefit. Means-testing the compensation against the

\textsuperscript{25} Ibid.
\textsuperscript{26} Ibid, at 4.
income of the care recipient, as is currently done with the tax credits and the allowance in Nova Scotia, is not adequately reflective of the needs of the caregiver. For this reason, if such benefits are means-tested, they ought to be means tested against the income of the caregiver so financial assistance and recognition is provided to the caregiver regardless of the financial circumstance of the care recipient, which may not bear any relation to the financial situation of the caregiver. A universal, rather than means-tested, form of compensation is preferable because distinguishing between caregivers based on earnings overlooks the inherent value of caregiving, and the acknowledgement by the state of the importance of care work. Further, implementing means-testing ignores the financial obligations that a high earner may have that reduce what might otherwise be disposable income. If the compensation is not universal, means-testing ought to be considerate of the actual circumstances of a caregiver, including the presence of a working partner, the presence of children or other dependants, and the costs of living in the location of the caregiver. To the extent that universal rights-based benefits are easier to administer, the cost of compensation on a universal basis could be mitigated by the reduced bureaucratic burden on the state.

Employment Related Benefits

The provision of the CCB through the EI Act raises a number of concerns, as discussed in Chapter 4. Depending on the extent to which an ideal political and social reorganization is sought, linking financial benefits to employment is a fundamental problem with this regime. The ‘Universal Caregiver’ model promoted by Nancy Fraser, for example, does not support this linkage. Rather, a guaranteed annual income would be provided to those engaged in both market and non-market work, stemming from the idea that taking time to ‘care’ is not unusual or an interruption to what one ‘ought’ to be doing, that is, engaged in market labour.

Taking a more practical view, however, the reality is that Canada’s social and political order will likely remain focused on the social member as worker paradigm.

27 Fraser, *supra* note 6.
of a neo-liberal welfare state. If this is correct then providing benefits in relation to employment may be a very practical solution. Indeed, to the extent that Fraser’s ideal paradigm is the model to which we aspire, it is important to ensure financial stability for caregivers until that happens. To this end, then, providing benefits to employed caregivers is a practical and realistic part of the solution. The CCB, however, is a highly problematic way of providing such benefits. As the analysis above shows, the up-take rate for the CCB is incredibly low. Eligibility requirements are stringent, and do not necessarily accord with the reality of caregiving in Canada. In particular, the program’s narrow focus on end-of-life care, while a very important aspect of caregiving, is too narrow. As discussed above, the duration of benefits provided is also too short, not enabling sufficient flexibility for care relationships.

Currently, the EI Act provides just six weeks of benefits despite the fact that many caregiving relationships extend much beyond this time and often involve care recipients who are not near death. Furthermore, the needs of care recipients are likely to be variable throughout the course of the caregiving relationship, and often will increase as they near death and are increasingly incapacitated.

In accordance with adopting flexible solutions, and encouraging flexibility in the workplace, a program that acknowledges the on-going nature of care relationships, and provides income replacement for periods taken away from the labor market will be the most effective solution. Using the EI Act may be the most practical way to do this, but changes to the eligibility requirements, for this benefit in particular but hopefully for other benefits as well, would be required.

A program that, permits the equivalent of 30 to 50 weeks of protected leave from the workplace, spread over the course of two or three years, might be an adequate solution. This would no doubt be difficult for employers to implement as it creates uncertainty in their labour force. However, given the long duration of many care relationships, an agreement between the employer and employee detailing their intended course of action over several years may lessen the burden faced by the employer, and enable the employer to hire part-time assistance or re-allocate job
responsibilities. This would permit the caregiver to work on a part-time basis, as demanded by their care responsibilities. Having a clear understanding of the ailment faced by their care recipient, though difficult and often uncertain, could assist her long-term planning with her employer. Providing income support through the EI Act to cushion the days or weeks away from the workforce ensures short-term and long-term economic security. This solution would also alleviate caregiver strain from an earlier point in the caregiving relationship, leading to improved physical and mental health outcomes for the caregiver.

One aspect of such a program being offered through the EI Act is that the benefit level, currently 55 percent of an applicant’s income in their qualifying period, may have to be increased in order to accommodate financial security over a longer period of time. Income replacement at closer to 90 percent would likely be required. Another change to increase the value of the benefit is to exclude from the calculation of benefit levels the 40% reduction in a caregiver’s earnings currently in place, and instead calculate the value of the benefit on the caregiver’s average earnings prior to their reduction in work. Finally, a level of benefits more reflective of a caregiver’s actual market attachment may require looking beyond her previous year’s employment. For example, basing her benefit level on her average insurable earnings for the preceding five years may be a more appropriate way to calculate benefit levels. This approach is consistent with the reality that a caregiver is likely to reduce her workforce attachment in the months, even years, preceding the death of the care recipient, inevitably reducing the value of her CCB.

Likewise, eligibility requirements would have to be correspondingly loosened to ensure broader access to such a program. Reducing the number of insurable hours required for eligibility is the first step to increasing eligibility. Perhaps returning to a weeks-worked rather than hours-worked system would increase women’s eligibility for such a benefit. Another approach could be to extend the ‘qualifying period’ beyond the current 26 to 52-week period, during which 600 hours of insurable earnings must be accumulated. Extending this period to several years, over which the 600 hours could be accumulated, would reflect women’s more contingent attachment
to the workforce as well as the likelihood of a caregiver having reduced her participation in the paid workforce to provide care.

Creating a longer period of benefits would accommodate eligibility for caregivers providing care to non-terminal, but highly dependent care recipients. A chronic ailment, a significant accident or injury, or a terminal illness on the part of the care recipient would all entitle a caregiver to a benefit pursuant to this reformed benefit program. This approach would recognize equally the demands of caregiving for both terminally ill and highly dependent but not terminally ill care recipients. It would also be more consistent with an approach that evaluates the circumstances of the caregiver, rather than the care recipient, one of the goals enunciated at the outset of this chapter.

Funding an expansion to the CCB, by extending the duration, increasing the value, or broadening the class of eligible employees, could be done either entirely through the EI regime, or through federal monetary support. As discussed in Chapter 4, the estimated costs of the CCB were roughly $86 million for the first year, and $221 million for years thereafter.\(^\text{28}\) As the cost of the CCB has actually only been three and a half percent of its projected cost, there is likely a surplus within the EI Regime itself to fund these recommendations.\(^\text{29}\) This would not implicate any direct financing from the federal government, and instead would rely on the projected budgets for the program.

A workplace that accommodates departures for care related reasons is a pre-condition to the provision of employment related benefits. As discussed previously, Alberta is the only province that has not adopted a statutory protection for employees to take time out of work to provide care to a dying relative. Making this change in Alberta is necessary, even in the face of data indicating that the up-take of the CCB is not adversely affected by the lack of a statutory provision protecting workers. While all other jurisdictions in Canada have adopted such provisions, envisioning a benefit tied


\(^{29}\) See Appendix “B”: Access to Information Request.
to work that extends beyond the current CCB will require the implementation of statutory protection for workers that mirrors the federally implemented solution. This will likely be the most difficult aspect of such a solution, as it undermines the ability of employers to draw on a consistent and fully engaged workforce. However, such a change is a necessary shift in the way the state views caregiving and the significance of care relationships. Canada’s current social policy provides a generous parental leave to new parents, reflecting the importance and significance of infant care. Providing employment protection parents to provide for infant care has been deemed by legislators, then, to trump the disruptions visited on employers caused by new parents taking time away from work. Viewing care by employees for terminally ill or frail elderly people ought to be accorded similar value, supporting reforms to the CCB that lengthen its duration.

One year of protected leave from employment is provided to new mothers on the basis that the care provided by mothers to their new children is an important and valued part of our society, and disruptions to an employers business cannot trump the importance of this relationship. Likewise, providing care to an ailing dependent ought to be viewed as equally important, and equally able to trump the employer’s interest.

In the context of caregiver employment protection, it may be possible to draw on the Irish solution of anti-discrimination legislation protecting caregivers. The legislation in Ireland prohibits the termination of an employee on the grounds of her status as a caregiver.30 Anti-discrimination legislation for the workplace is one step to alleviating the precarious employment situation that many caregivers face, but the solution will require legislative action by way of extending the currently available leaves provided for caregiving. This could be accomplished by amending both

---

provincial human rights codes, and the federal *Canadian Human Rights Act*, to include status as a caregiver as an analogous ground.\(^\text{31}\)

**Taking Care of the Caregiver**

This chapter has so far highlighted policy options aimed at increasing the financial stability of caregivers. There are a number of other ways that social policy can ensure that caregivers can themselves be taken care of. This section will evaluate how respite services, training programs, and accessible support services can operate to take care of caregivers.

Empirical data on the physical health of caregivers shows that caregiving takes a toll on the health of caregivers.\(^\text{32}\) By offering respite services to caregivers, we can ensure that they can rest properly and take time to attend to their physical condition, whether that means increasing time for fitness or attending to their own medical conditions by accessing health services. Proper nutrition is also critical for caregivers, who may be busy preparing special food items for the care recipient and overlook their own nutritional needs. Programs like meals on wheels operate in many Canadian jurisdictions and are financed through private donations and many volunteer hours.\(^\text{33}\) Continued support for such programs will ensure that they can continue to provide nutritious food to both care recipients and their caregivers.

Quebec acknowledges the importance of respite services, as evidenced by their introduction of a tax credit that a caregiver can allocate to those who have provided respite services. The significance of this is not the value of the credit, which is a

---


\(^{32}\) Morris *supra* note 5, at 95.


117
maximum of $500 for each respite provider, and totals $1000 for each caregiver, but the significance of the recognition of the respite volunteers.\textsuperscript{34} Introducing a similar credit across Canada would ensure jurisdictional consistency of benefits available to caregivers.

Respite care is also recognized in Quebec through the tax credit available to offset costs associated with professional respite services.\textsuperscript{35} Although the value of the benefit is not particularly helpful, it is certainly a step in the right direction to provide financial assistance to caregivers. It also offers important recognition of the work of caregivers, and their need for public assistance. Care recipients with complex care needs or with some conditions, such as Alzheimer’s, may not be able to be cared for on a respite basis by a volunteer respite care provider, which makes specialized respite care all the more important to the caregiver.

Caregivers are expected to undertake a range of quasi-medical tasks, including administering medications, monitoring vital signs, and sometimes even more invasive procedures such as giving injections or changing catheters. There is very little in the way of formal training for informal caregivers, and the quality of their instruction will often depend on the nurse or other health professional with whom they are dealing. These over-burdened health professionals may not have time to provide detailed instructions, or troubleshooting advice. Further, the capacity of the caregiver to absorb the information is variable, as they are likely in an exhausted and overwhelmed position. Other factors such as education and proficiency with English language will also influence their ability to properly understand directions. Establishing standard training courses for informal caregivers with appropriate resources and follow-up is important. Topics can be tailored to the specific needs of caregivers, but will include learning about signs that the care recipient’s condition is worsening, or learning about the physical and emotional stages of dying. The training could also include important information about how the caregiver can take the best care of themselves. Most importantly, providing the caregiver with

\textsuperscript{34} Taxation Act, R.S.Q. I-3, art. 1029.8.61.71 – 1029.8.61.75.
\textsuperscript{35} Ibid, art. 1020.8.61.76 – 1029.8.61.82.
information about the resources available to them will empower the caregivers and ensure they avail themselves of these services. One of the most time-consuming and frustrating aspects of caregiving, as reported by caregivers, is coordinating services, determining what services are available and from where.\textsuperscript{36} Social workers could be tasked with routine follow-ups to ensure that caregivers are making appropriate use of community resources.

A 2008 report by the Caledon Institute for Social Policy documenting the experiences of caregivers caring for dementia patients focused heavily on the need for respite services.\textsuperscript{37} Whether the services are provided in the home of the care recipient, or institutionally, respite services enable caregivers to rest, sleep and attend to their own needs for a period of time. Caregiver health is improved when they use respite services. However, the report concluded that there are still barriers to the uptake of respite services provided by both government and non-profit community organizations.\textsuperscript{38} Institutional respite programs, where a patient can be placed for a day or week, face the problem of being unwelcoming to the patient. This is particularly problematic for dementia patients who may not understand or be comfortable to the placement, which can be difficult depending on the degree of mental impairment of the recipient.\textsuperscript{39}

Incorporating more extensive respite programs into provincial home care services will ameliorate the physical and emotional strain faced by caregivers, ultimately leading to improved health outcomes. This will likely reduce the caregivers’ own health care expenditures, and will more readily enable their re-entry into the labour market following the completion of their caregiving duties. Both outcomes are economically beneficial to society at large.

\\textsuperscript{36} Caledon Policy Report, supra note 10, at 19.
\textsuperscript{37} Ibid.
\textsuperscript{38} Ibid, at 26.
\textsuperscript{39} Ibid, at 23.
Indirect Support for Caregivers

In addition to the direct and indirect financial compensation discussed in the previous sections, there are two ways to reduce the financial strain of caregivers that will be briefly reviewed prior to concluding this chapter. Neither of these policy proposals directly impact caregivers, but instead impact care recipients in a way that could reduce the burden faced by their caregivers. The first is increasing the public provision of care to include palliative and post-acute home care within the mandate of the CHA or as part of a federal-provincial agreement. The second is to reduce the cost of prescription drugs through mandatory universal prescription drug insurance.

Public Provision of Care

One way to ease the burden faced by caregivers is to increase the level of formal care provided by the state. The review, above, of the home care services provided in three Canadian provinces, indicates a strong trend toward means-testing for many ancillary care services. However, health care needs that fall within the mandate of the CHA are free of charge when delivered at home, though this is limited to services such as a physician or nurse visit.

Policy reports produced for the federal government recommend the inclusion of palliative care or post-acute home care services within the mandate of the CHA.\(^40\) The Romanow Commission recommended that the CHA be expanded to include post-acute home care as a medically necessary service, including both medication and rehabilitation.\(^41\) The same report recommended the inclusion of palliative care services in the CHA for people in the last six months of their lives.\(^42\) Both of these recommendations would alleviate a significant degree of caregiver strain, but neither have been adopted. The Kirby Report also recommended a national palliative care

---


\(^{41}\) Romanow Report, *ibid*, at 176.

\(^{42}\) *Ibid.*
home program and a national post acute home care program, both to be funded on a 50/50 basis between the federal and provincial governments.\textsuperscript{43}

The lack of action on these recommendations since they were put forward is not a promising sign that these changes will be implemented in the near future. With continued attention on the significance of caregiving relationships, perhaps these changes will gain momentum and be implemented. Until that happens, advocating for direct support for caregivers may be more realistic, and may bring about the most significant and meaningful changes to the lives of caregivers.

\textit{Universal Prescription Drug Insurance}

One of the main out-of-pocket expenses of caregivers is purchasing prescription medication for the care recipient. Without a universal prescription drug insurance program, Canadian care recipients outside of Quebec may have no private insurance to offset prescription drug costs. Many private insurance programs are provided through employment, and a care recipient that is not employed or considered a dependent of an employee will not have access to such insurance. Employed caregivers with prescription drug insurance may, depending on their policy, include a care recipient as a dependent, but as this thesis has demonstrated, the participation of a caregiver in paid employment, entitling her to ancillary benefits such as private insurance, is increasingly difficult as her care obligations increase.

All Canadian provinces offer prescription drug insurance for seniors, but these programs do not universally address the needs of all care recipients.\textsuperscript{44} For one, the care recipient may not meet the age threshold to be eligible for the plan. Second, the means-testing requirements imposed by some plans may exclude or insufficiently cover residents who may have high prescription drug costs but whose income is too high to qualify them for the program. Ontario, for example, provides prescription drug coverage to individuals on social assistance or who are age 65 or over, and there

\textsuperscript{43} Kirby Report, \textit{supra} note 14, at 164.
\textsuperscript{44} Virginie Demers, \textit{et al.}, “Comparison of provincial prescription drug plans and the impact on patients’ annual drug expenditures” (2008) 178 Canadian Medical Association Journal 405.
is a separate program for those who do not meet these requirements but have high prescription drug costs in relation to their income.\(^{45}\)

Quebec is the only province with a universal prescription drug insurance program.\(^{46}\) Residents are required to either enroll in the provincial plan or to show that they have equal or better private insurance provided by an employer. Residents in Quebec are still required to pay part of the costs of their prescription medication in most cases, but the cost is greatly reduced. Introducing a universal drug insurance program in other provinces would likely fall under provincial jurisdiction unless it were included in reforms to the \textit{CHA}, and would require action on the part of each province independently. The cost of the program for each province would depend on a number of factors, and to a large extent, would depend on how many residents are privately insured versus how many residents enroll in the provincial program. The other variable in estimating the cost of such a program is what percentage of the drugs the insurance covers, and how much is paid by the customer.

\textbf{Governmental Responsibility for Policy Developments}

The division of powers between the federal and provincial governments complicates coherent and consistent policy development across the country. Figure 3 summarizes up the policy suggestions outlined in this chapter and indicates which level of government is responsible for each recommendation. As discussed at the outset of this chapter, in order to adequately implement most of these changes, a significant degree of cooperation will be required between both levels of government.

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Level of Government</th>
</tr>
</thead>
<tbody>
<tr>
<td>Changes to the \textit{CPP} to implement a “drop-}</td>
<td>Federal</td>
</tr>
<tr>
<td>Action</td>
<td>Level</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------</td>
<td>---------</td>
</tr>
<tr>
<td>“out” provision for caregivers.</td>
<td></td>
</tr>
<tr>
<td>Changes to <em>ITA</em> to create RRSP room for caregivers.</td>
<td>Federal</td>
</tr>
<tr>
<td>Changes to federal <em>ITA</em>.</td>
<td>Federal</td>
</tr>
<tr>
<td>Changes to provincial income tax legislation.</td>
<td>Provincial</td>
</tr>
<tr>
<td>Allowance/Direct financial compensation for caregivers.</td>
<td>Provincial</td>
</tr>
<tr>
<td>Changes to the <em>EI Act</em> to expand eligibility requirements, duration and value of the CCB.</td>
<td>Federal</td>
</tr>
<tr>
<td>Changes to employment standards legislation to mirror provisions in <em>EI Act</em>.</td>
<td>Provincial</td>
</tr>
<tr>
<td>Including “caregiver status” in human rights legislation</td>
<td>Provincial &amp; Federal</td>
</tr>
<tr>
<td>Introducing comprehensive respite programs for caregivers.</td>
<td>Provincial</td>
</tr>
<tr>
<td>Training programs for caregivers.</td>
<td>Provincial</td>
</tr>
<tr>
<td>Including palliative care as a “medically necessary” service within the <em>CHA</em>.</td>
<td>Federal</td>
</tr>
<tr>
<td>Universal prescription drug insurance.</td>
<td>Provincial</td>
</tr>
</tbody>
</table>

**Fig. 3. Governmental Responsibility for Policy Reform**

The most urgent reforms must take place at the provincial level, namely the amendments to provincial employment standards legislation in provinces with inadequate provisions to enable caregivers to take a protected period of leave to use the CCB. Most notably, Alberta must take action to introduce a protected period of leave for caregiving employees.
Conclusion

This chapter suggested a number of policy reforms to ameliorate the strains faced by caregivers. Using the empirical evidence discussed in Chapter 1, the theoretical orientation discussed in Chapter 2, the review and evaluation of current policies in Chapters 3 and 4, and finally, the international perspectives surveyed in Chapter 5, this chapter has brought all these ideas together to make concrete suggestions for reform. Ranging from practical and possible, to more idealistic, this chapter has offered both direct and indirect measures that can assist caregivers. The most significant policy reform suggested is the change to the CCB. Whether or not all of the changes to the benefit are adopted, even modest changes to eligibility, duration or value would improve this benefit. It is hoped that any government action to assist caregivers will be meaningful and respectful of the important role of caregiving in our society. As demands for caregiving increase in the coming years, these policy solutions can help provide a road-map of options for legislators and advocates.
Conclusion

This conclusion brings us back to where this thesis began: the idea that dependencies are inevitable in everyone’s life course, and a society that inadequately cares for its caregivers is not a just society. Thinking back to the personal anecdote from the introduction: to what extent would the current policies in place in Canada help the caregivers in my family, and to what extent would the reforms suggested in Chapter 6 have ameliorated the situation of the fictional character of Mary? Current policies offering financial support for caregivers would have been of some use to Mary, but the value of these benefits would unlikely have made a significant difference to her position because they address only short-term financial strains. Changes to the Canada Pension Plan and the RRSP rules in the Income Tax Act would likely have a far more meaningful impact on a caregiver in Mary’s position, because they address the long-term financial strains associated with caregiving. Likewise, a comprehensive respite program would have assisted Mary by improving her physical health outcomes and ensuring that she had time and energy to participate in civic activities. Changes to the Compassionate Care Benefit (the “CCB”) to make it longer or available to those caring for non-terminal care recipients would increase the likelihood that someone in Mary’s position would take advantage of the benefit. Finally, including palliative care in the Canada Health Act would give caregivers the ability to make a choice about whether or how much care work they want or can provide, without compromising their own health and stability.

The ultimate aim of this thesis was to propose concrete policy solutions to help improve both the financial and physical health of caregivers, and to ensure that their caregiving demands do not detract from their ability to participate fully in society. This conclusion will offer some final thoughts about this project, and moving forward.
Concluding Thoughts

When I initially approached this topic, my understanding and my aims were motivated by a personal connection to caregiving. In writing this thesis, I came to three conclusions. First, I am not alone, let alone unique, for having a personal connection to caregiving. The topics discussed in this thesis are of fundamental importance not only to those who actively provide care on a daily basis, but to those who have aging parents or friends, or to those who face dependencies themselves. Informal caregiving is increasingly becoming not an if situation for Canadians, but a when. The demographic and political factors discussed in Chapter 2 that point to increasing demands on caregivers in the coming years suggest that most Canadians will be impacted by informal caregiving, either directly or indirectly.

The second conclusion is that more work needs to be done to adequately understand caregiving and the best ways to support it. Though new research appeared constantly over the course of writing this thesis, there is a specific lack of qualitative, first-hand data about the experiences of caregivers in Canada, and in particular, their experiences with social policies currently in place. This absence is likely directly related to the loss of voice that caregivers experience as a result of their work giving care. The theme emerged throughout both my research and in this thesis, that not only are the thoughts and experiences of many caregivers not heard, the caregivers simply do not have the energy, time or resources to make their voices heard. Those who work in research fields and have the time to read and write on the subject, simply cannot grasp the needs, frustrations, or the joys associated with caregiving. To that end, as academics advocating for policy change, we need to work more with caregivers, rather than for them.

The third conclusion was evident early in the process of writing this thesis, and it is the extent to which this is a truly inter-disciplinary area of research. Approaching the topic of informal caregiving from a legal perspective, I initially anticipated working with laws and government policies, with which I am familiar. I realized that understanding laws and policies will only help if I can understand who is giving care, the political and social context in which the care is given, and the theoretical
rationales for supporting caregiving. The only way for effective legal and policy change is to understand the components giving rise to the need for a particular policy, as well as how the implementation of that policy actually unfolds on the ground. As a result, my work in this thesis spanned a number of fields: philosophy, sociology, political science, gender and women’s studies, nursing, human geography, public policy and medicine. The implication of the inter-disciplinary nature of this area of work is the importance of continued collaboration amongst these fields of study to ensure that research is adequately accessible to those studying informal caregiving. To the extent that this thesis can help inform the work of those in diverse fields of study, I made the conscious decision to write this thesis in an accessible way, to further the continued knowledge sharing that must take place to bring about changes to help support informal caregivers.

Signs of Change for the Future

Recent changes to policies, including the introduction of the CCB in 2004, and more recently, tax changes in Manitoba and Quebec and the caregiver allowance in Nova Scotia, are promising developments. They indicate that governments are slowly becoming aware of the burdens faced by caregivers, and are willing to make small changes to help caregivers. It is my hope with this thesis that federal and provincial governments will continue to make these incremental changes. As the first chapter of this thesis outlined, the need for informal caregivers is poised to increase as the ‘baby-boomer’ generation ages. Caregiving is about to move from the periphery to the main focus of many Canadian’s lives, and implementing policy changes before this happens will ensure that caregivers can continue their labour of love, and maintain their voice in Canadian society.
Appendix “A” – Definitions of “Family Member”

The following chart indicates how “family member” is defined in each province or territory’s employment standards legislation. The definition in the Employment Insurance Act and the Canada Labour Code are also included. Alberta is excluded from the table because it does not provide a statutory leave of absence for employees providing compassionate care.

<table>
<thead>
<tr>
<th></th>
<th>BC</th>
<th>MB</th>
<th>SK</th>
<th>ON</th>
<th>QC</th>
<th>NL</th>
<th>NS</th>
<th>PE</th>
<th>NB</th>
<th>YK</th>
<th>NW</th>
<th>NU</th>
<th>LC</th>
<th>EI</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>In relation to an Employee</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spouse</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Child</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Parent</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Grandparent</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Grandchild</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Sibling</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Step-sibling</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Aunt/Uncle</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Niece/Nephew</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

7. *Labour Standards Code*, R.S.N.S. 1989, c.246, s. 60(E); *General Labour Standards Code Regulations*, N.S. Reg. 298/90, s. 7(c)(2).
13. Employment Insurance Act, R.S.C. 1996, c. 23, s. 23.1; Employment Insurance Regulations, SOR/96-332, s. 41.11.
<table>
<thead>
<tr>
<th>Current or Former foster Parent</th>
<th>BC</th>
<th>MB</th>
<th>SK</th>
<th>ON</th>
<th>QC</th>
<th>NL</th>
<th>NS</th>
<th>PE</th>
<th>NB</th>
<th>YK</th>
<th>NW</th>
<th>NU</th>
<th>LC</th>
<th>EI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current or Former foster Child</td>
<td>✔</td>
<td>✔</td>
<td>-</td>
<td>✔</td>
<td>-</td>
<td>-</td>
<td>✔</td>
<td>-</td>
<td>-</td>
<td>✔</td>
<td>-</td>
<td>-</td>
<td>✔</td>
<td>-</td>
</tr>
<tr>
<td>Current or former ward</td>
<td>✔</td>
<td>✔</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>✔</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Current or former guardian</td>
<td>✔</td>
<td>✔</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>✔</td>
<td>-</td>
</tr>
</tbody>
</table>

**The spouse of the Employee’s**

| Sibling or step-sibling         | ✔  | ✔  | -  | ✔  | -  | -  | ✔  | -  | -  | ✔  | -  | -  | ✔  | -  |
| Parent                          | ✔  | -  | ✔  | ✔  | ✔  | ✔  | -  | -  | -  | ✔  | -  | -  | ✔  | -  |
| Child or step-child            | ✔  | -  | ✔  | -  | -  | -  | ✔  | -  | -  | ✔  | -  | -  | ✔  | -  |
| Grandparent                    | ✔  | ✔  | -  | ✔  | -  | -  | -  | -  | -  | ✔  | -  | -  | ✔  | -  |
| Grandchild                     | ✔  | ✔  | -  | ✔  | -  | -  | -  | -  | -  | ✔  | -  | -  | ✔  | -  |
| An aunt or uncle               | ✔  | ✔  | -  | ✔  | -  | -  | -  | -  | -  | ✔  | -  | -  | ✔  | -  |
| A niece or nephew              | ✔  | ✔  | -  | ✔  | -  | -  | -  | -  | -  | ✔  | -  | -  | ✔  | -  |
| A current or former foster child | ✔  | ✔  | -  | -  | -  | -  | ✔  | -  | -  | ✔  | -  | -  | ✔  | -  |
| A current or former guardian   | ✔  | ✔  | -  | -  | -  | -  | ✔  | -  | -  | ✔  | -  | -  | ✔  | -  |
| A current or former ward       | -  | ✔  | -  | -  | -  | -  | -  | -  | -  | -  | -  | -  | -  | -  |

**In relation to the Employee’s spouse**

| A parent or step-parent        | ✔  | ✔  | ✔  | ✔  | -  | -  | ✔  | -  | -  | ✔  | -  | -  | ✔  | -  |
| Sibling or step-sibling        | ✔  | ✔  | ✔  | ✔  | -  | -  | ✔  | -  | -  | ✔  | -  | -  | ✔  | -  |
| Sibling or step-sibling in-law | -  | -  | -  | -  | -  | -  | -  | -  | -  | -  | -  | ✗  | ✗  | ✗  |

---

15 Only current foster child, rather than current or former.
16 Saskatchewan excludes step-parents of the employee’s spouse.
17 Saskatchewan excludes step-siblings of the employee’s spouse.
<table>
<thead>
<tr>
<th></th>
<th>BC1</th>
<th>MB2</th>
<th>SK3</th>
<th>ON4</th>
<th>QC5</th>
<th>NL6</th>
<th>NS7</th>
<th>PE8</th>
<th>NB9</th>
<th>YK10</th>
<th>NW11</th>
<th>NU12</th>
<th>LC13</th>
<th>EI14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>-</td>
<td>-</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Grandparent</td>
<td>✓</td>
<td>✓</td>
<td>-</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>-</td>
<td>-</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Grandchild</td>
<td>✓</td>
<td>✓</td>
<td>-</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>-</td>
<td>-</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Step-grandchild</td>
<td>-</td>
<td>-</td>
<td>✓</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Step-grandparent</td>
<td>-</td>
<td>-</td>
<td>✓</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Child – in law</td>
<td>-</td>
<td>-</td>
<td>✓</td>
<td>-</td>
<td>✓</td>
<td>-</td>
<td>-</td>
<td>✓</td>
<td>-</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Aunt or Uncle</td>
<td>✓</td>
<td>✓</td>
<td>-</td>
<td>✓</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Niece or nephew</td>
<td>✓</td>
<td>✓</td>
<td>-</td>
<td>✓</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>A current or former foster parent</td>
<td>✓</td>
<td>✓</td>
<td>-</td>
<td>✓</td>
<td>✓</td>
<td>-</td>
<td>-</td>
<td>✓</td>
<td>-</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>A current or former foster child</td>
<td>-</td>
<td>✓</td>
<td>-</td>
<td>✓</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>A current or former ward</td>
<td>✓</td>
<td>✓</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>A current or former guardian</td>
<td>-</td>
<td>✓</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Person whom the employee considers to be like a close relative</td>
<td>✓</td>
<td>✓</td>
<td>-</td>
<td>✓</td>
<td>-</td>
<td>-</td>
<td>✓</td>
<td>-</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

18 Includes current foster parent only, rather than former foster parent of the employee’s spouse.
On October 23, 2009, a request for information pursuant to the Access to Information Act was made to Human Resources and Skills Development Canada. The following records were requested:

“1. Number of applicants for the Compassionate Care Benefit (the “Benefit”) offered through the Employment Insurance Act, on an annual basis since its inception. If available, a gender and age breakdown is requested.
2. Number of applicants denied and number accepted for the Benefit, on an annual basis since its inception. Again, if available, a gender and age breakdown is requested.
3. Average duration of the Benefit for those to whom it is given, in terms of weeks, on an annual basis since its inception. Again, a gender and age breakdown is requested if available.
4. Average amount received pursuant to the Benefit, both on a weekly and aggregate basis, on an annual basis since its inception. A gender and age breakdown is requested if available.
5. Total amount, both annually and aggregated, of benefits paid pursuant to the Benefit, since its inception.”

On November 23, 2009, the following information was provided:

“1. Number of applicants for the Compassionate Care Benefit (the “Benefit”) offered through the Employment Insurance Act, on an annual basis since its inception. If available, a gender and age breakdown is requested.
We cannot provide age and gender breakdown. Since inception, here are the annual volumes of claims intake for the Compassionate Care Benefits are as follows:

<table>
<thead>
<tr>
<th>YEAR</th>
<th>INTAKE</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>5,587</td>
</tr>
<tr>
<td>2005</td>
<td>5,220</td>
</tr>
<tr>
<td>2006</td>
<td>6,607</td>
</tr>
<tr>
<td>2007</td>
<td>6,663</td>
</tr>
<tr>
<td>2008</td>
<td>7,483</td>
</tr>
<tr>
<td>2009*</td>
<td>4,638</td>
</tr>
</tbody>
</table>

2. Number of applicants denied and number accepted for the Benefit, on an annual basis since its inception. Again, if available, a gender and age breakdown is requested.

We cannot provide age and gender breakdown. Since Inception, here are the annual volumes of claims allowed and denied Compassionate Care Benefits are as follows:

<table>
<thead>
<tr>
<th>YEAR</th>
<th>ALLOWED</th>
<th>DENIED</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>3,982</td>
<td>1,605</td>
</tr>
<tr>
<td>2005</td>
<td>3,711</td>
<td>1,509</td>
</tr>
<tr>
<td>2006</td>
<td>4,863</td>
<td>1,744</td>
</tr>
<tr>
<td>2007</td>
<td>4,837</td>
<td>1,826</td>
</tr>
<tr>
<td>2008</td>
<td>5,207</td>
<td>2,276</td>
</tr>
<tr>
<td>2009*</td>
<td>3,162</td>
<td>1,476</td>
</tr>
</tbody>
</table>
3. Average duration of the Benefit for those to whom it is given, in terms of weeks, on an annual basis since its inception. Again, a gender and age breakdown is requested if available.

We cannot provide age and gender breakdown. Since Inception, the average duration of claims for Compassionate Care Benefit was:

<table>
<thead>
<tr>
<th>YEAR</th>
<th>Average Duration (Weeks)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>5.5</td>
</tr>
<tr>
<td>2005</td>
<td>5.9</td>
</tr>
<tr>
<td>2006</td>
<td>5.3</td>
</tr>
<tr>
<td>2007</td>
<td>5.6</td>
</tr>
<tr>
<td>2008</td>
<td>5.5</td>
</tr>
<tr>
<td>2009*</td>
<td>5.7</td>
</tr>
</tbody>
</table>

4. Average amount received pursuant to the Benefit, both on a weekly and aggregate basis, on an annual basis since its inception. A gender and age breakdown is requested if available.

SEB / EI Policy to provide.

5. Total amount, both annually and aggregated, of benefits paid pursuant to the Benefit, since its inception.

The annual and total amounts of Compassionate Care Benefits paid annually since inception are:

<table>
<thead>
<tr>
<th>YEAR</th>
<th>Benefits Paid</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>$6,889,000</td>
</tr>
</tbody>
</table>
*All 2009 values are year-to-date September 20, 2009 *" 

A Chart was also provided, entitled “Annex 2.12 – Compassionate Care Benefits” which breaks down the age and gender of recipients of the CCB. A breakdown by province was also included. Below is reproduced the gender breakdown provided, followed by the provincial breakdown:

<table>
<thead>
<tr>
<th></th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Claims</td>
<td>% Change ’06/’07 – ‘07/’08</td>
<td>4.3</td>
</tr>
<tr>
<td></td>
<td>2007/2008</td>
<td>1,475</td>
</tr>
<tr>
<td></td>
<td>2006/2007</td>
<td>1,414</td>
</tr>
<tr>
<td></td>
<td>2005/2006</td>
<td>1,372</td>
</tr>
<tr>
<td></td>
<td>2004/2005</td>
<td>1,256</td>
</tr>
<tr>
<td>Average Number of Weeks Paid</td>
<td>% Change ’06/’07 – ‘07/’08</td>
<td>2.0</td>
</tr>
<tr>
<td></td>
<td>2007/2008</td>
<td>4.8</td>
</tr>
<tr>
<td></td>
<td>2006/2007</td>
<td>4.7</td>
</tr>
<tr>
<td></td>
<td>2005/2006</td>
<td>4.8</td>
</tr>
<tr>
<td></td>
<td>2004/2005</td>
<td>4.7</td>
</tr>
<tr>
<td>Average Weekly</td>
<td>% Change ’06/’07 –</td>
<td>2.8</td>
</tr>
<tr>
<td>Benefit</td>
<td>‘07/’08</td>
<td>2.8</td>
</tr>
<tr>
<td>---------</td>
<td>---------</td>
<td>-----</td>
</tr>
<tr>
<td>2007/2008 ($)</td>
<td>374</td>
<td>326</td>
</tr>
<tr>
<td>2006/2007 ($)</td>
<td>364</td>
<td>318</td>
</tr>
<tr>
<td>2005/2006 ($)</td>
<td>361</td>
<td>306</td>
</tr>
<tr>
<td>2004/2005 ($)</td>
<td>357</td>
<td>299</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Amount Paid (SMillions)</th>
<th>% Change ’06/’07 – ‘07/’08</th>
<th>2007/2008</th>
<th>6,778.9</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007/2008</td>
<td></td>
<td>2,770.0</td>
<td></td>
</tr>
<tr>
<td>2006/2007</td>
<td></td>
<td>2,523.7</td>
<td>6,571.8</td>
</tr>
<tr>
<td>2005/2006</td>
<td></td>
<td>2,455.1</td>
<td>5,351.8</td>
</tr>
<tr>
<td>2004/2005</td>
<td></td>
<td>2,139.1</td>
<td>4,781.0</td>
</tr>
</tbody>
</table>

Number of new claims, by province:

<table>
<thead>
<tr>
<th>Province/Territory</th>
<th>2007/08</th>
<th>2006/07</th>
<th>2005/06</th>
<th>2004/05</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newfoundland and Labrador</td>
<td>69</td>
<td>76</td>
<td>72</td>
<td>72</td>
<td>289</td>
</tr>
<tr>
<td>Prince Edward Island</td>
<td>31</td>
<td>31</td>
<td>33</td>
<td>34</td>
<td>129</td>
</tr>
<tr>
<td>Nova Scotia</td>
<td>219</td>
<td>195</td>
<td>197</td>
<td>181</td>
<td>792</td>
</tr>
<tr>
<td>New Brunswick</td>
<td>167</td>
<td>153</td>
<td>116</td>
<td>123</td>
<td>559</td>
</tr>
<tr>
<td>Quebec</td>
<td>943</td>
<td>935</td>
<td>869</td>
<td>809</td>
<td>3,556</td>
</tr>
<tr>
<td>Ontario</td>
<td>2,418</td>
<td>2,447</td>
<td>2,284</td>
<td>1,883</td>
<td>9,032</td>
</tr>
<tr>
<td>Manitoba</td>
<td>236</td>
<td>227</td>
<td>205</td>
<td>189</td>
<td>857</td>
</tr>
<tr>
<td>Saskatchewan</td>
<td>158</td>
<td>182</td>
<td>148</td>
<td>162</td>
<td>650</td>
</tr>
<tr>
<td>Alberta</td>
<td>512</td>
<td>491</td>
<td>504</td>
<td>515</td>
<td>2,022</td>
</tr>
<tr>
<td>British Columbia</td>
<td>939</td>
<td>922</td>
<td>718</td>
<td>808</td>
<td>3,387</td>
</tr>
<tr>
<td>Nunavut</td>
<td>3</td>
<td>7</td>
<td>7</td>
<td>3</td>
<td>20</td>
</tr>
<tr>
<td>Northwest Territories</td>
<td>4</td>
<td>3</td>
<td>12</td>
<td>7</td>
<td>26</td>
</tr>
<tr>
<td>Yukon</td>
<td>9</td>
<td>7</td>
<td>13</td>
<td>7</td>
<td>36</td>
</tr>
</tbody>
</table>
Bibliography

Legislation & Regulations: Canada (Federal, Provincial & Territorial)


Amendments to the Employment Insurance Regulations, SOR/2006-135

An Act respecting labour, R.S.Q. c. N-1.1

An Act respecting parental insurance, R.S.Q. c. A-29.011

An Act respecting prescription drug insurance, R.S.Q. c. A-29.01

Budget Implementation Act, S.C. 2003, c. 15, s. 19

Canada Health Act, R.S.C. 1985, c. C-6


Canada Pension Plan, R.S.C. 1985, c. C-8

Canadian Human Rights Act, R.S.C. 1985, c. H-6

Charter of human rights and freedoms, R.S.Q. c. C-12

Compassionate Care Leave Regulation, B.C. Reg. 281/2006


Constitution Act, 1940 (U.K.), George VI 3 & 4, c. 36.

Employee Standards Act, S.N.B. 1982, c. E-7.2

Employment Insurance Act, R.S.C.1996, c. 23

Employment Insurance Regulations, SOR/96-332

All internet sources were last checked on April 29, 2010.
Employment Standards Act, 2000, S.O. 2000, c. 42

Employment Standards Act, R.S.B.C. 1996, c. E-113

Employment Standards Act, R.S.P.E.I. 1988, c. E-6.2

Employment Standards Act, R.S.Y. 2002, c. 72


Employment Standards Code, R.S.A. 2000, c. E-9

Employment Standards Code, C.C.S.M. c. E-110


Employment Standards Regulation, O. Reg. 476/06

Fairness for the Self-Employed Act, S.C. 2009, c. 33

General Labour Standards Code Regulations, N.S. Reg. 298/90

Human Rights Act, S.Nu. 2003, c. 12


Human Rights Act, S.N.W.T. 2002, c. 18

Human Rights Act, R.S.N.S. 1989, c. 214


Human Rights Act, R.S.Y. 2002, c. 116

Human Rights Code, R.S.B.C. 1996, c. 210


Human Rights Code, R.S.O. 1990, c. H.19


Income Tax Act, R.S.C. 1985, c. 1 (5th Supp.)

Income Tax Act, R.S.B.C. 1996, c. 215

Income Tax Act, R.S.N.S. 1989, c. 217
Income Tax Act, R.S.O. 1990, c. I.2
Income Tax Act, 2000, R.S.S. 2000, c. I-2.01
Labour Standards Act, R.S.N.L. 1990, c. L-2
Labour Standards Act, R.S.S. 1978, c. L-1
Labour Standards Code, R.S.N.S. 1989, c. 246
Labour Standards Act, R.S.N.W.T. 1988, c. L-1, as duplicated for Nunavut by s. 29 of the Nunavut Act, S.C. 1993, c. 28
Ontario Drug Benefit Act, R.S.O. 1990, c. O-10
Ontario Drug Benefit Act General Regulation, O. Reg. 201/96
Taxation Act, R.S.Q. I-3
The Income Tax Act, C.C.S.M. c. I10
Legislation: International

Carer’s Leave Act, 2001 (2001 No. 19), online: Irish Statute Book

Consolidation Act on Social Services, online: Denmark Ministry of Social Affairs


Equal Status Act, 2000 (2000, No. 8), online: Irish Statute Book

Social Services Act, SFS 2001:453, promulgated June 7, 2001, online: Ministry of Health and Social Affairs, Sweden
<http://www.sweden.gov.se/content/1/c6/04/34/02/9d488738.pdf>


Jurisprudence

In the Matter of the Employment Insurance Act and in the matter of a claim for benefits by Anglea Ings and in the matter of an appeal by the claimant from the decision of a Board of Referees given on December 20, 2005 at London Ontario (July 28, 2006,) Canadian Umpire Benefit no. 66451, online: Service Canada: <http://www.aei.gc.ca/policy/appeals/cubs/60000-70000/66000-66999/66451E.html>

In the Matter of the Employment Insurance Act and in the matter of a claim for benefit by Donna Robinson and in the matter of an appeal by the Commission from a decision of a Board of Referees given at Windsor, ON, on the 13th day of October, 2005 (August 3, 2007,) Canadian Umpire Benefit no. 67803, online: Service Canada: <http://www.aei.gc.ca/policy/appeals/cubs/60000-70000/67000-67999/67083E.html>
*In the matter of the Employment Insurance Act and in the matter of a claim for benefit by Ang Ly and in the matter of an appeal by the Commission from a decision of a Board of Referees given at Kitchener, ON, on the 7th day of April, 2006 (May 10, 2007,) Canadian Umpire Benefit no. 66399A, online: Service Canada: <http://www.ae-ei.gc.ca/policy/appeals/cubs/60000-70000/66000-66999/66399AE.html>*


**Secondary Sources: Articles, Books & Reports**


Gilligan, Carol. *In a different voice: Psychological theory and women’s development* (Cambridge, Mass.: Harvard University Press, 1982)

Greaves, Lorraine *et al.* “Final Payments: Socio-economic Costs of Palliative Home Caregiving in the Last Month of Life” (Health Canada, Women’s Health Bureau, 2002) online: Centres of Excellence for Women’s Health <http://www.cewh-cesf.ca/PDF/cross_cex/final-payments.pdf>


Feder Kittay, Eva. *Love’s labor: essays on women, equality and dependency* (New York: Routledge, 1999)


Netto, Nicholas, et al. “Growing and gaining through caring for a loved one with dementia” (2009) 8 Dementia 245

O'Shea, Eamon. “Costs and Consequences for the Carers of People with Dementia in Ireland” (2003) 2 Dementia 201,


Sanders, Sara. “Is the Glass Half Empty or Half Full? Reflections on Strain and Gain in Caregivers of Individuals with Alzheimer’s Disease” (2005) 40 Social Work in Health Care 57


Torjman, Sherri & Anne Makhoul, “Caregivers and Dementia” (Ottawa: Caledon Institute of Social Policy, 2008), online: Caledon Institute of Social Policy <http://www.caledoninst.org/Publications/PDF/680ENG%2Epdf>


Williams, Allison, et al. “Evaluating Canada’s Compassionate Care Benefit: From the Perspective of Family Caregivers” (Hamilton, Ont.: School of Geography and Earth Sciences, 2010), online: Canadian Caregiver Coalition <http://www.ccc-ccan.ca/media.php?mid=287>

Tronto, Joan C. Moral boundaries (New York: Routledge, 1993)


**Secondary Sources: Government & Other Documents**


Canadian Labour Congress, “Statement by the Canadian Labour Congress to the House of Commons Standing Committee Regarding the Status of Women Study on the Consequences and Effects the Current Employment Insurance (EI) Programs Have on Women in Canada” March 5, 2009, online: Canadian Labour Congress
Department of Finance Canada, “Canada Health Transfer” online: Department of Finance Canada <http://www.fin.gc.ca/fedprov/cht-eng.asp>


EUROFAMCARE, “Project Description” online: EUROFAMCARE <http://www.uke.de/extern/EUROFAMCARE/beschreibung.php>


Nova Scotia Department of Health, “Caregiver Allowance” online: Nova Scotia Department of Health, Continuing Care Branch
<www.gov.ns.ca/health/ccs/caregiver_allowance.asp>

The Government of Canada and the Government of Quebec, “Canada – Quebec Final Agreement on the Quebec Parental Insurance Plan” online: Empoli et Solidarité Sociale Québec
<http://www.rqap.gouv.qc.ca/a_propos_regime/documentation_en.asp?categorie=030021#publications>

Ontario Ministry of Health and Long-Term Care, “Ontario Public Drug Programs: Publicly Funded Drug Programs” online: Ontario Ministry of Health and Long-Term Care
<http://www.health.gov.on.ca/english/providers/program/drugs/funded_drug/funded_drug.html>

Ontario Ministry of Health and Long-Term Care, “Senior’s Care: Arranging Care” online: Ontario Ministry of Health and Long-Term Care
<www.health.gov.on.ca/english/public/program/ltc/18_care_mn.html>


Régie de l’assurance maladie Québec, “Prescription Drug Insurance: Private Plans: For Whom” online: Régie de l’assurance maladie Québec

Santé et Services Sociaux Québec, “Plan D’Action: Un defi de solidarité - Les services aux aines en perte d'autonomie, 2005-2010” online: Santé et Services Sociaux Québec

Service Canada, “Canada Pension Plan: Retirement Pension” (Ottawa: Service Canada, 2008), online: Service Canada

Service Canada, “Employment Insurance (EI) and the family supplement” online: Service Canada <http://www.servicecanada.gc.ca/eng/ei/service/family_supplement.shtml>


“2010 Tax Credits – Basic Amounts” online: TaxTips <http://www.taxtips.ca/nrcredits/nrcredits2010base.htm>