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# The Legal Treatment of Informal Caregivers of the Elderly in Canada and Australia: The Importance of Recognizing Relations in Creating Reforms

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**THE LEGAL TREATMENT OF INFORMAL CAREGIVERS OF THE ELDERLY  
IN CANADA AND AUSTRALIA:  
THE IMPORTANCE OF RECOGNIZING RELATIONS IN CREATING REFORMS**

**SARA PON**

**A THESIS SUBMITTED TO THE FACULTY OF GRADUATE STUDIES  
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## ABSTRACT

This thesis examines the policy implications of the legal treatment of caregivers of the elderly in Canada and Australia and how this can inform law and policy reforms in Canada. Legislation and policy on the formal care system and supports for informal caregivers of the elderly in Canada and Australia are described, with a focus on BC and Ontario in Canada. These supports are analyzed and evaluated through the lens of relational autonomy. Australia for the most part has more supports than Canada, although improvements can be made to these supports to make them more effective in supporting informal caregivers in Canada. My policy recommendations include increasing formal care for seniors, recognizing caregivers in legislation, requiring consultation with caregivers, providing a comprehensive and coordinated range of financial and employment supports, providing support for emotional and educational needs of informal caregivers, and increasing government-provided information on caregiving and available supports.

## DEDICATION

To my mother, Lottie, whose devotion to care is the inspiration for this work.

## ACKNOWLEDGEMENTS

I wish to thank my supervisor, Professor Joan Gilmour, for her invaluable input and encouragement through this process. I would also like to thank Professor Ruth Buchanan for her advice early on, and to Professor Pat Armstrong for her helpful feedback. Thank you to Professor Freya Kodar, who started me thinking about these issues at the University of Victoria. To my husband and family, thank you for giving me the time to create this work. Thank you to my daughter Clara, for giving me a new experience of care and love.

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## CHAPTER ONE: INTRODUCTION TO INFORMAL CARE WORK

In Canada, over eight million people are caring for an adult family member or friend.<sup>1</sup> The most common care recipient is an aging parent or spouse.<sup>2</sup> The number of seniors in Canada who need care has been increasing due to increased life expectancies, and the baby boomer generation having just begun to enter retirement.<sup>3</sup> Individuals are now living longer with functional limitations, chronic illnesses, disabilities, and other aging-related needs.<sup>4</sup> Care within Canada has been de-institutionalized, with most seniors receiving care within the home from either government-provided home care or informal sources such as family members.<sup>5</sup> The majority of care for these elderly Canadians is being provided by family members.<sup>6</sup> However, this care comes at a cost to informal caregivers, who face sometimes significant psychological, physical, employment, and income related impacts.<sup>7</sup> Legal reforms are needed in Canada to support those caring informally for elders.

### Outline of Thesis

My research question is what are the policy implications of the legal treatment of caregivers of the elderly in Canada and Australia and how can this inform law and policy reforms in Canada. Chapter 2 of this thesis examines the literature in the area of care work and

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<sup>1</sup>Canada, Statistics Canada, *Portrait of Caregivers, 2012*, by Marie Sinha, Catalogue No 89-652X No 001 (Ottawa: Statistics Canada, September 2013) [Sinha] at 4.

<sup>2</sup> Sinha, *ibid* at 5.

<sup>3</sup> British Columbia Law Institute, “Care/Work: Law Reform to Support Family Caregivers to Balance Paid Work and Unpaid Caregiving” (2010) BCLI Study Paper No. 4 [BCLI] at 16-17.

<sup>4</sup> BCLI, *ibid* at 17; Peggie Smith, “Elder Care, Gender, and Work: The Work-Family Issue of the 21st Century” (2004) 25 Berkeley Journal of Employment and Labour Law 351 [Smith, Elder Care] at 356-357.

<sup>5</sup> Nancy Guberman, “Designing Home and Community Care For the Future: Who Needs to Care?” in Karen R Grant, Carol Amaratunga, Pat Armstrong, Madeline Boscoe, Ann Pederson & Kay Willson, eds., *Caring For/Caring About: Women, Home Care, and Unpaid Caregiving* (Aurora, Ontario: Garamond Press, 2004) 75 at 76; Pat Armstrong & Hugh Armstrong, “Thinking It Through: Women, Work and Caring in the New Millennium” in Karen R Grant, Carol Amaratunga, Pat Armstrong, Madeline Boscoe, Ann Pederson & Kay Willson, eds., *Caring For/Caring About: Women, Home Care, and Unpaid Caregiving* (Aurora, Ontario: Garamond Press, 2004) 5 at 32-33.

<sup>6</sup> Pat Armstrong & Olga Kits, “One Hundred Years of Caregiving” in Karen R Grant, Carol Amaratunga, Pat Armstrong, Madeline Boscoe, Ann Pederson & Kay Willson, eds., *Caring For/Caring About: Women, Home Care, and Unpaid Caregiving* (Aurora, Ontario: Garamond Press, 2004) 45 at 48-53, 64.

<sup>7</sup> Christina Lee, “Health, Stress and Coping among Women Caregivers: A Review” (1999) 4(1) Journal of Health Psychology 27 at 30-32; Lynn McDonald, “Chapter 10. Gendered Retirement: The Welfare of Women and the “New” Retirement” in Leroy Stone, ed., *New Frontiers of Research on Retirement* (2005) 137 at 149-150, 157; Sule Alan, Kadir Atalay, & Thomas Crossley, “The Adequacy of Retirement Savings: Subjective Survey Reports by Retired Canadians” (2008) 34 Canadian Public Policy 95 at 97-111.



relational theory. I look at legal analyses of Canadian and Australian legal treatment of informal caregivers, as well as briefly discuss some of the sociological, political, and economic literature on elder care work. Additionally, I examine the literature on relational theory and its application to social reproduction. Chapter 3 discusses the methodology used in this thesis. Chapter 4 examines the legislation and policy for supports for elder care work in Canada as well as the basics of the formal care system for the elderly. British Columbia (BC) and Ontario are the focus of this chapter, although notable supports in other provinces are described. Chapter 5 examines the legislation and policy for supports for informal elder caregivers in Australia as well as its formal care system. Chapter 6 analyzes and evaluates the supports for caregivers in Canada and Australia, noting where the countries differ. The supports are examined through the lens of relational autonomy. In Chapter 7, I put forward policy recommendations for developing increased caregiver supports in Canada.

### **What is Informal Care Work?**

This thesis analyzes informal care work, which is care that is done within the home by a family member.<sup>8</sup> Informal caregivers are family members or close friends of the care recipient, who are any age; typically caregivers are female relatives.<sup>9</sup> Care recipients, for the purpose of this thesis, are defined as individuals who are 65 years of age or older and require care. Caregivers conduct a wide range of caregiving activities for the care recipient. Caregiving activities include helping with personal care, medications, managing care, home maintenance, cleaning, and emotional support.<sup>10</sup> Caregivers also provide transportation for activities such as taking care recipients to medical appointments or on errands.<sup>11</sup> Care activities include the terms activities of daily living (ADLs) and instrumental activities of daily living (IADLs).<sup>12</sup> ADLs are those involving personal care such as hygiene and basic medical care and IADLs are those tasks which are done regularly and need to be done to live independently, such as food preparation and

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<sup>8</sup> This is a definition which is commonly used in the caregiving literature. Guberman, *supra* note 5 at 75; Armstrong & Kits, *supra* note 6 at 48-53.

<sup>9</sup> This is a definition which is commonly used in the caregiving literature. Guberman, *ibid* at 75; Armstrong & Kits, *ibid* at 48-53.

<sup>10</sup> Wend Pyper, "Balancing Career and Care" (2006) 7:11 Perspectives on Labour and Income at 5; Sylvie Lafreniere, Yves Carriere, Laurent Martel, and Alain Belanger, "Dependant Seniors at Home – Formal and Informal Help" (2003) 14:4 Health Reports 31 at 32-33; Michael G Wilson, Francois-Pierre Gauvin, & Jenny Ploeg, Citizen Brief: Improving Care and Support for Unpaid Caregivers in Ontario (Hamilton, Canada: McMaster Health Forum, 8 Nov 2014) [McMaster Citizen Brief] at 4.

<sup>11</sup> Pyper, *ibid* at 5; Lafreniere et al, *ibid* at 32-33.

<sup>12</sup> This is a definition which is commonly used in the caregiving literature. Armstrong & Kits, *supra* note 6 at 47-48; BCLL, *supra* note 3 at 1, 20.

cleaning.<sup>13</sup> Women tend to perform the personal care, and men are more likely to perform instrumental activities such as transportation.<sup>14</sup>

Informal care work by family is part of a larger network of care which seniors in Canada can receive. This thesis focuses on home care, informal care work, and caregiver supports in BC and Ontario.<sup>15</sup> In BC, formal health care from the government can take the form of home care, assisted living, or residential care.<sup>16</sup> Home care can include nursing care, rehabilitation services, adult day programs, and home support services such as assistance with personal hygiene and mobility.<sup>17</sup> Assisted living is intended to provide seniors with a residential setting where they have independence in decisions about care and their day to day activities, but receive hospitality services and may receive some assistance with daily activities or minor medical care if needed.<sup>18</sup> Residential care is provided to seniors who cannot live on their own and need residential services, nursing care, and personal care, among other services.<sup>19</sup>

Ontario provides a similar structure for formal care to that of BC. Clients can receive home services such as health care and personal care.<sup>20</sup> Long-term care homes are available for clients who cannot live independently and need health care and other assistance on a continuous basis.<sup>21</sup> In both provinces, informal care work takes the role of providing care which the government-provided home care would not, and care for those who are not eligible for home care services or only eligible for partial services.

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<sup>13</sup> BCLI, *ibid* at 20; Gal Wettstein & Alice Zulkarnain. “How Much Long-term Care do Adult Children Provide?” (2017) 17:11 Issue in Brief: Center for Retirement Research at Boston College 1 at 1.

<sup>14</sup> Cara Williams, “The Sandwich Generation” (2004) 5:9 Perspectives on Labour and Income 5 at 8.

<sup>15</sup> See Chapter 3 for why BC and Ontario were chosen as the focus, and Chapter 4 for a more thorough description of the Canadian and provincial health care system.

<sup>16</sup> British Columbia, Ministry of Health, *Home and Community Care Policy Manual*, January 2016 update [BC H&CC Policy Manual] at 4.A, 4.B, 5.B; British Columbia, Office of the Ombudsperson, *The Best of Care: Getting it Right for Seniors In British Columbia(Part 2) Overview*, Public Report No 47 to the Legislative Assembly of British Columbia (2012) [Best of Care] at 69.

<sup>17</sup> BC H&CC Policy Manual, *ibid* at 4.A 1 of 3.

<sup>18</sup> BC H&CC Policy Manual, *ibid* at 5.B, 5.B.3; Best of Care, *supra* note 16 at 47-48. Hospitality services are defined in s 1 the *CCALA* as “...meal services, housekeeping services, laundry services, social and recreational opportunities and a 24 hour emergency response system;” *Community Care and Assisted Living Act*, SBC 2002, c 75. While this may be the stated intent of assisted living, research has found assisted living to not live up to the intention of allowing independence (see page 46, Molly M Perkins et al., “Relational Autonomy in Assisted Living: A Focus on Diverse Care Settings for Older Adults” (2012) 26 J Aging Studies 214 at 215; Susan Sherwin & Meghan Winsby, “A Relational Perspective on Autonomy for Older Adults Residing in Nursing Homes” (2010) 14 Health Expectations 182 at 183, 189).

<sup>19</sup> Best of Care, *ibid* at 69.

<sup>20</sup> Province of Ontario, “Home and Community Care” <[https://www.ontario.ca/page/homecare-seniors?\\_ga=1.146438259.675571647.1445550345](https://www.ontario.ca/page/homecare-seniors?_ga=1.146438259.675571647.1445550345)> [Ont H&CC Website].

<sup>21</sup> Ontario Seniors’ Secretariat, *A Guide to Programs and Services for Seniors in Ontario*, <<http://www.seniors.gov.on.ca/en/seniorsguide/>> [Seniors’ Secretariat Guide] ch 1 at 7; O Reg 79/10 s 155.

Informal caregiving of the elderly is something which a great number of Canadians will experience during their lifetime both as caregivers and care recipients. Several studies and government reports have examined the prevalence of informal care work in Canada. Informal care work is a major part of the health care system.<sup>22</sup> Research places the number of caregivers of the elderly in Canada around 1.7 million to 2.7 million.<sup>23</sup> The number of seniors is expected to double, and the oldest old groups are expected to increase by more than double.<sup>24</sup> The demographics of the country are also changing, with the number of seniors in Canada now larger than the number of children.<sup>25</sup> Care may be provided solely by informal caregivers, or a mix of formal and informal care – results from the General Social Survey (GSS) found that about half of care recipients received just informal care, and the remainder received either formal or a mix of informal and formal care.<sup>26</sup> Care recipients tend to need more hours of care as they get older.<sup>27</sup> Care recipients with no children received more formal care than those with children.<sup>28</sup> The 2012 GSS found that parents were the most common care recipients, and aging needs the most common reason for needing care among surveyed family caregivers.<sup>29</sup>

The number of hours of care work that the caregiver provides does differ among caregivers and among studies. For example, the 2012 GSS found that caregivers reported a median of 3 hours of care work per week, although this went up to 14 hours if caring for a spouse.<sup>30</sup> Most caregivers spent under 10 hours per week caring, especially those caring for someone with aging issues, although caring for a spouse was the most common reason for performing 30 or more hours of care work a week.<sup>31</sup> The number of caregiving hours differs in other studies - a literature review by Christina Lee found that caregivers spend an average of 6.5

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<sup>22</sup> Pyper, *supra* note 10 at 5; Janice Keefe & Pamela Fancey, “Compensating Family Caregivers: An Analysis of Tax Initiatives and Pension Schemes” (1999) 7 Health Law Journal 193 at 193; BCLI, *supra* note 3 at 3, 18.

<sup>23</sup> Pyper, *ibid* at 5; BCLI, *ibid* at 18; McMaster Citizen Brief, *supra* note 10 at 3.

<sup>24</sup> McMaster Citizen Brief, *ibid* at 7.

<sup>25</sup> Statistics Canada, “Age and sex, and type of dwelling data: Key results from the 2016 Census” (2017) The Daily, Component of Statistics Canada catalogue no 10-001-X at 3.

<sup>26</sup> Kelly Cranswick & Derrick Thomas, “Elder Care and the Complexities of Social Networks”(2005) 77 Canadian Social Trends 10 at 10-11; Lafreniere et al., *supra* note 10 at 34; Canada, Statistics Canada, *Canadians with Unmet Home Care Needs*, by Martin Turcotte, Catalogue No 75-006-X (Ottawa: Statistics Canada, 9 September 2014) [Turcotte, Unmet Needs] at 6.

<sup>27</sup> Cranswick & Thomas, *ibid* at 12-13; Lafreniere et al., *ibid* at 37.

<sup>28</sup> Lafreniere et al., *ibid* at 38.

<sup>29</sup> Sinha, *supra* note 1 at 5. Aging related needs was not defined further in the context of the GSS.

<sup>30</sup> Sinha, *ibid* at 7. Up from a median of two hours per week in the 2002 GSS - Pyper, *supra* note 10 at 5-6.

<sup>31</sup> Sinha, *ibid* at 7; Pyper, *ibid* at 5-6.

hours per day performing care work.<sup>32</sup> A new study by the Canadian Institute for Health Information found that caregivers of seniors spent an average of 17 hours per week caring, with the number going up to 26 hours per week for those caring for seniors with dementia.<sup>33</sup> Women are frequently found to provide more care work and spend more hours in care work than men.<sup>34</sup> Among women, caregivers are most commonly the wife or daughter of the care recipient.<sup>35</sup>

### **Why is Informal Caregiving of the Elderly an Issue Now?**

Literature has examined what parts of informal care work have remained the same over time, and what aspects of care work have changed. Family members have always provided care for their relatives and friends, and caregivers have always been predominantly women.<sup>36</sup> Concerns about how to care for aging populations are not new, and entering institutionalized care has always been limited to some degree.<sup>37</sup> Household composition and family structure have also been more diverse than traditionally thought, even though women still do most of the caring.<sup>38</sup> There are some very important changes though. Individuals are living a lot longer due to universal health care and better health care, health technology, nutrition, working conditions, and public health measures such as immunization.<sup>39</sup> Individuals are both living into old age healthier, and living longer with chronic illnesses, thus requiring more care.<sup>40</sup> Women are increasing their labour force participation while still performing care work, which is leading to more time constraints.<sup>41</sup> Importantly for women, the type of care that needs to be done is becoming more complex. With the increase in day surgery and outpatient medical care and the decrease of formal medical care, individuals are coming home while still requiring complex medical care.<sup>42</sup> This care is falling to women, who do not have the training to provide these medical services.<sup>43</sup>

Informal care work has become predominant because care has been shifted from being

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<sup>32</sup> Lee, *supra* note 7 at 31.

<sup>33</sup> Canadian Institute for Health Information, *Dementia in Canada* (Ottawa: Canadian Institute for Health Information, 2018), online: <<https://www.cihi.ca/en/dementia-in-canada>> [CIHI, *Dementia in Canada*].

<sup>34</sup> Pyper, *supra* note 10 at 5-6; Lee, *ibid* at 29; Williams, *supra* note 14 at 8; BCLI, *supra* note 3 at 19.

<sup>35</sup> Lee, *ibid* at 29.

<sup>36</sup> Armstrong & Kits, *supra* note 6 at 64-65.

<sup>37</sup> Armstrong & Kits, *ibid* at 59.

<sup>38</sup> Armstrong & Kits, *ibid* at 51-53, 60.

<sup>39</sup> Armstrong & Kits, *ibid* at 61-62.

<sup>40</sup> Armstrong & Kits, *ibid* at 62.

<sup>41</sup> Armstrong & Kits, *ibid* at 63-65.

<sup>42</sup> Armstrong & Kits, *ibid* at 62-65.

<sup>43</sup> Armstrong & Kits, *ibid* at 62-65.

provided in institutions to being provided within the community.<sup>44</sup> The state has shifted this care to the community in order to reduce costs and wait lists, and as a response to the increase in the number of seniors within the population.<sup>45</sup> This change has been rationalized on the basis that studies on the determinants of health reported that patients would receive better care at home than in an institution.<sup>46</sup> Care at home is seen as more personalized and less expensive.<sup>47</sup> Research has demonstrated that receiving care from family members enables seniors with chronic illnesses to remain independent longer, and remain within their homes or communities longer than those without informal care.<sup>48</sup> Seniors themselves express desires to stay within their communities and be independent for as long as possible before entering institutionalized care.<sup>49</sup> The deinstitutionalization of care is based on an assumption that it is better for health and independence for seniors to receive care at home. While care has been said to have been moved into the ‘community’, the fact is that most of this care work is done by family members without pay, not by community organizations or local health care.<sup>50</sup> Formal health care services are only used when the family cannot fulfill all of the care needs.<sup>51</sup> The only two options for most individuals are informal care by family members or institutionalized care, thus understandably most see family care as the only desirable option in that circumstance.<sup>52</sup> Unpaid care work is largely unseen in the public or government eye unless there is a serious problem.<sup>53</sup>

Nancy Guberman challenges this assumption that informal care at home is best or even preferred. She argues that if there were more options than just informal care or institutionalization, seniors would make other choices.<sup>54</sup> This is based on the fact that those with sufficient economic resources choose to purchase care services, or move into housing that provides care services to its residents; in those circumstances, family members are left to only

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<sup>44</sup> Guberman, *supra* note 5 at 76.

<sup>45</sup> Guberman, *ibid* at 76.

<sup>46</sup> Guberman, *ibid* at 76; Armstrong & Armstrong, *supra* note 5 at 32-33.

<sup>47</sup> Armstrong & Armstrong, *ibid* at 32.

<sup>48</sup> Smith, Elder Care, *supra* note 4 at 357; Pyper, *supra* note 10 at 5.

<sup>49</sup> Cranswick & Thomas, *supra* note 26 at 10, BCLI, *supra* note 3 at 11.

<sup>50</sup> Guberman, *supra* note 5 at 76.

<sup>51</sup> Guberman, *ibid* at 76.

<sup>52</sup> Guberman, *ibid* at 77.

<sup>53</sup> Jane Aronson & Sheila M Neysmith, “The Retreat of the State and Long-Term Care Provision: Implications for Frail Elderly People, Unpaid Family Carers and Paid Home Care Workers” (1997) 53 *Studies in Political Economy* 37 at 47.

<sup>54</sup> Guberman, *supra* note 5 at 77; Aronson & Neysmith, *ibid* at 42-46.

provide emotional or social support.<sup>55</sup> Seniors report that they do not wish to become a burden to their families, and wish to maintain some distance and independence from family members.<sup>56</sup> Women see their family caregivers as the best of the bad options they have for care.<sup>57</sup> Guberman argues that more choices are needed to allow seniors to remain independent but still get the needed care, thus being more active citizens.<sup>58</sup> Aronson and Neysmith note that policies on elder care assume that elders are able to be independent actors who are choosing from whom they receive care freely within the marketplace, but that this is in fact not the case.<sup>59</sup> With the background of financial constraints in health care, policy makers are concerned adding choices could decrease informal care work.<sup>60</sup> But research has demonstrated that family will not stop caring, but may change the type of care they are providing.<sup>61</sup>

There is an assumption in the reliance on informal care work that family members are good caregivers.<sup>62</sup> Policy-makers assume that families will be kind, supportive, have adequate skills to properly care, and not experience or inflict violence or abuse within the home.<sup>63</sup> These assumptions entrench the gendering of care work and the traditional family form by creating norms that care should be performed by women in the home.<sup>64</sup> However, family forms are becoming increasingly diverse, and seniors do not always have families that are physically or emotionally close.<sup>65</sup> Women may not be caring out of choice or love; women may feel forced to do care work due to the lack of any other option for their relative to obtain needed care, and due to pressure to conform to societal gender roles.<sup>66</sup> Family members may also experience abuse or violence which may create situations which are not safe to conduct care work.<sup>67</sup>

### **The Gendered Nature of Care Work**

#### *Social Science Studies on Gender Differences*

Women conduct the majority of the unpaid work within the home, including childcare,

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<sup>55</sup> Guberman, *ibid* at 77.

<sup>56</sup> Guberman, *ibid* at 77-78; Aronson & Neysmith, *supra* note 53 at 42-46.

<sup>57</sup> Aronson & Neysmith, *ibid* at 44 to 46.

<sup>58</sup> Guberman, *supra* note 5 at 77-78.

<sup>59</sup> Aronson & Neysmith, *supra* note 53 at 42-46.

<sup>60</sup> Guberman, *supra* note 5 at 78.

<sup>61</sup> Guberman, *ibid* at 78-79.

<sup>62</sup> Guberman, *ibid* at 79.

<sup>63</sup> Guberman, *ibid* at 79-80.

<sup>64</sup> Guberman, *ibid* at 79-80.

<sup>65</sup> Guberman, *ibid* at 79-80.

<sup>66</sup> Guberman, *ibid* at 81; Nicholas T Bott, Clifford C Sheckter, & Arnold S Milstein, "Dementia Care, Women's Health, and Gender Equity The Value of Well-Timed Caregiver Support" (2017) 74:7 JAMA Neurology 757.

<sup>67</sup> Guberman, *ibid* at 79.



eldercare, and housework.<sup>68</sup> Studies and surveys have found that between 70 and 75% of the care work is done by women.<sup>69</sup> Women have been steadily doing the same amount of unpaid work in the home since the 1960s, but women's participation in the paid workforce has been growing, meaning women have to increasingly balance care work and paid work.<sup>70</sup> Family caregivers surveyed in the 2012 GSS were most commonly between 45 and 64, which is consistent with past studies; the average age of caregivers matches the fact that seniors were the most common care recipient in this survey.<sup>71</sup> Among female caregivers, 23% are the spouse of the care recipient, 29% are the child of the care recipient, and 20% are another relative.<sup>72</sup> Among children of care recipients, daughters are three times more likely to be providing care work than sons.<sup>73</sup> Women do the majority of care for both their parents and their husband's parents.<sup>74</sup> Due to women's longer life expectancies than men, women also represent a higher proportion of the care recipients.<sup>75</sup>

Past studies have found that women do about twice as many hours of care work as men.<sup>76</sup> However, the 2012 GSS found that women and men provided a similar median amount of care work – 4 hours for women and 3 for men.<sup>77</sup> Women are more likely to be caring at least 20 hours per week, and men are more likely to be providing only 1 hour of care work per week.<sup>78</sup> Also, women are more likely to be helping multiple people.<sup>79</sup> Women perform more high-intensity care work than men.<sup>80</sup> High-intensity care work was described by Wendy Pyper as 4 or more

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<sup>68</sup> Freya Kodar, "Pension (In)Securities: Unpaid Work, Precarious Employment and the Canadian Pension System" (2004) 28:2 *Atlantis* 93 [Kodar, Pension (In)securities] at 95; Marika Morris, "What Research Reveals About Gender, Home Care and Caregiving: Overview and the Case For Gender Analysis" in Karen R Grant, Carol Amaratunga, Pat Armstrong, Madeline Boscoe, Ann Pederson & Kay Willson, eds., *Caring For/Caring About: Women, Home Care, and Unpaid Caregiving* (Aurora, Ontario: Garamond Press, 2004) 91 at 91-92.

<sup>69</sup> BCLI, *supra* note 3 at 19; Lee, *supra* note 7 at 29; Smith, *Elder Care*, *supra* note 4 at 360.

<sup>70</sup> BCLI *ibid* at 19; McDonald, *supra* note 7 at 139.

<sup>71</sup> Sinha, *supra* note 1 at 5, 12; Lee, *supra* note 7 at 29.

<sup>72</sup> Lee, *ibid* at 29.

<sup>73</sup> Lee *ibid* at 29.

<sup>74</sup> Smith, *supra* note 4 at 361.

<sup>75</sup> Smith, *ibid* at 377; Cranswick & Thomas, *supra* note 26 at 12.

<sup>76</sup> Pyper, *supra* note 10 at 8.

<sup>77</sup> Sinha, *supra* note 1 at 10. (The 2012 GSS survey defined caregivers as "...providing help or care within the past 12 months to either: 1) someone with a long-term health condition or a physical or mental disability, or 2) someone with problems related to aging." Thus, this would cover caregivers of family members of any age, but would exclude people caring for a child without a long-term health condition or disability. Sinha at 10).

<sup>78</sup> Sinha, *ibid* at 10.

<sup>79</sup> Morris, *supra* note 68 at 94.

<sup>80</sup> Pyper, *supra* note 10 at 6.

hours of care work per week.<sup>81</sup> This type of care work is associated with more socio-economic consequences for the caregiver.<sup>82</sup> Men experience fewer socio-economic consequences than women, partially due to men performing more of the low-intensity care work.<sup>83</sup>

The types of care tasks that women perform also differ from that which men perform. Women perform more of the regular caregiving tasks such as medical care, while men carry out more of the periodic care tasks, such as those that can be performed when convenient for the caregivers.<sup>84</sup> Women perform both ADL and IADL care, and are more likely to perform personal care and housework.<sup>85</sup> Men typically only perform IADL care such as transportation and home maintenance, and men who perform ADL care are less likely to do intimate types of care such as bathing.<sup>86</sup> Women travel more to perform caregiving activities for recipients who live far from the caregiver.<sup>87</sup> Caregiving activities have a bigger impact on everyday activities for women compared to men, such as changing vacations, education plans, and residences.<sup>88</sup> The health and well-being of women is negatively affected to a greater extent than for men.<sup>89</sup>

#### *Sandwich Generation & Precarious Employment*

Women are increasingly being caught in what is termed the ‘sandwich generation’.<sup>90</sup> This occurs when women are caring for both minor children and an elder family member.<sup>91</sup> Women are also often in paid work while caring for both their children and elder relatives.<sup>92</sup> In the 2002 GSS, of the 2.6 million people with children under 25 at home, 27% were performing elder care.<sup>93</sup> The fact that women had children at home did not significantly change the amount of elder care being done – those with children at home performed an average of 19.6 hours of elder care per month, and those without children at home performed an average of 26.4 hours of elder care per month.<sup>94</sup> This number is holding steady, with the 2012 survey finding that 28% of

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<sup>81</sup> Pyper, *ibid* at 6.

<sup>82</sup> Pyper, *ibid* at 6-7.

<sup>83</sup> Pyper, *ibid* at 6-7;

<sup>84</sup> Morris, *supra* note 68 at 94; Sinha, *supra* note 1 at 10-11.

<sup>85</sup> Smith, Elder Care, *supra* note 4 at 362; Williams, *supra* note 14 at 8.

<sup>86</sup> Smith, Elder Care, *ibid* at 362; Williams, *ibid* at 8.

<sup>87</sup> Morris, *supra* note 68 at 94.

<sup>88</sup> Morris, *ibid* at 93-94.

<sup>89</sup> Morris, *ibid* at 94-96.

<sup>90</sup> BCLI, *supra* note 3 at 19; Smith, *supra* note 4 at 365; McDonald, *supra* note 7 at 155.

<sup>91</sup> BCLI, *ibid* at 19.

<sup>92</sup> BCLI, *ibid* at 19; Williams, *supra* note 14 at 7.

<sup>93</sup> Williams, *ibid* at 6; BCLI, *ibid* at 19.

<sup>94</sup> Williams, *ibid* at 7.



family caregivers were ‘sandwiched’.<sup>95</sup>

Women are more likely to be in precarious employment than men, and this can lead to increased problems for women when engaging in caregiving activities.<sup>96</sup> Precarious employment is work which is more likely to be part-time or temporary in nature, and has fewer benefits and lower pay.<sup>97</sup> However, employment status does not explain the gender differences in the amount of elder care done by women compared to men.<sup>98</sup>

Because women are in lower paying jobs and have to take time out of paid work for family caregiving, they are more likely to be living in poverty.<sup>99</sup> Women take time out for caring for both children and elders, leading to fewer employment hours to accrue pension benefits.<sup>100</sup> As well, caregiving responsibilities interfere with jobs more for women than men, as the caregiving activities men do can more easily be done outside of paid work hours.<sup>101</sup>

Despite the numerous differences in care work between men and women, it cannot be ignored that there are still important differences in caregiving responsibilities among women. For example, the less formal education a woman has, the more hours of care work she provides, as those with higher education generally have greater economic resources to purchase care services.<sup>102</sup> Women living in rural areas perform more hours of and more intensive care work than women living in urban areas.<sup>103</sup> Caregivers and care recipients who are indigenous, visible minorities, or immigrants face more burdens and impacts due to increased systemic obstacles.<sup>104</sup>

#### *Socialization of Gender Roles in Care Work*

Social science literature posits that women are socialized into their role as caregivers. Care work has been classified by society as a ‘female’ activity.<sup>105</sup> This classification has been reinforced by society through socialization of children, and through how government creates

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<sup>95</sup> Sinha, *supra* note 1 at 12.

<sup>96</sup> House of Commons, Standing Committee on the Status of Women. *Pension Security for Women: Report of the Standing Committee on the Status of Women* (December 2009) (Chair: Hon. Hedy Fry, MP) [Report of Standing Committee] at 6; Kodar, Pension (In)securities, *supra* note 68 at 93-95.

<sup>97</sup> Kodar, Pension (In)securities, *ibid* at 94.

<sup>98</sup> Morris, *supra* note 68 at 93.

<sup>99</sup> Jay Ginn, *Gender, Pensions, and the Lifecourse: How Pensions Need to Adapt to Changing Family Forms* (Bristol, UK: The Policy Press, 2003) at 90.

<sup>100</sup> Report of Standing Committee, *supra* note 96 at 3, 6-7.

<sup>101</sup> Morris, *supra* note 68 at 97.

<sup>102</sup> Morris, *ibid* at 93.

<sup>103</sup> Morris, *ibid* at 102-103.

<sup>104</sup> Morris, *ibid* at 101-102.

<sup>105</sup> Loretta Brewer, “Gender Socialization and the Cultural Construction of Elder Caregivers” (2001) 15 *Journal of Aging Studies* 217 at 220; Morris, *ibid* at 106.

social policies to reinforce compliance with these societal norms.<sup>106</sup> Socialization into gender norms aids in creating differences between genders in terms of power and social class.<sup>107</sup>

Loretta Brewer notes an important distinction in the literature between sex and gender.<sup>108</sup> Sex is the biological difference between men and women, but gender is the behaviors that are categorized as ‘male’ or ‘female’.<sup>109</sup> Children learn how they should behave through observing how those around them are acting, trying out behaviours, and retaining those which are rewarded.<sup>110</sup> Studying other cultures shows that Canada’s gendered care work pattern is not present in every culture – in some, care for elders either falls on the son or is split equally between women and men.<sup>111</sup>

Social science research demonstrates that care work is something which has been socially created to be women’s work, not something which biology has determined.<sup>112</sup> Children learn through watching and imitating that women do the care work, and this is reinforced by social policies that allow or reinforce this distinction.<sup>113</sup> The gendered nature of care work is something which can start to be shifted through developing social policies that aim to support care work by both sexes and not subordinate women by placing them into positions of being forced to provide care work without the proper supports.<sup>114</sup>

Not all feminists view gender as simply socially constructed and thus able to be altered through social policies and legislation. For example, the ‘ethic of care’ proposed by Carol Gilligan views women as more caring than men due to their ability to connect with others.<sup>115</sup> Care work is not necessarily tied to women, but care is a feminine voice that is distinct from the masculine voice.<sup>116</sup> The masculine voice focuses on justice and individualism, while the feminine voice focuses on caring for others and one’s responsibilities toward others.<sup>117</sup> This position has been criticized in that it fails to address the differences within each gender, because

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<sup>106</sup> Brewer, *ibid* at 220; Morris, *ibid* at 106.

<sup>107</sup> Brewer, *ibid* at 221.

<sup>108</sup> Brewer, *ibid* at 222.

<sup>109</sup> Brewer, *ibid* at 222.

<sup>110</sup> Brewer, *ibid* at 222.

<sup>111</sup> Brewer, *ibid* at 222, 228-230.

<sup>112</sup> Brewer, *ibid* at 231.

<sup>113</sup> Brewer, *ibid* at 231.

<sup>114</sup> Brewer, *ibid* at 231-232.

<sup>115</sup> Brewer, *ibid* at 224.

<sup>116</sup> Brewer, *ibid* at 224-225.

<sup>117</sup> Brewer, *ibid* at 225-226.

some women may not want to or be capable of caring, and some men do focus on care.<sup>118</sup>

Due to the gendered nature of care work, my research and analysis focuses primarily on female caregivers. Women are primarily considered as a whole, but differences between women in patterns and impacts of care work are noted. The analysis examines how caregiver supports in Canada and Australia impact all women, and how they may differ for women in different socio-economic locations. This thesis also focuses on a feminist analysis, relational autonomy (discussed in the next chapter), to ensure a proper assessment of elder care policies and law on women.

### Impacts on Caregivers

Research has found that informal caregivers experience a range of physiological and psychological impacts from this care work. Christina Lee conducted a literature review of studies on caregiving impacts over many countries, including Canada, the USA, and Australia, and found that most studies had caregivers reporting they felt burdens associated with their caregiving duties.<sup>119</sup> Emotional impacts of care work include stress, depression, feeling overwhelmed, and feeling isolated.<sup>120</sup> Caregivers may also have less time to spend on their personal and social interests.<sup>121</sup> Emotional impacts are greater when the care recipients have certain health conditions such as a terminal illness, having Alzheimer's disease, having dementia, or presenting with abusive behaviours.<sup>122</sup> Caregivers who perform few hours of care work experience fewer impacts than caregivers who spend many hours caring.<sup>123</sup> Physical impacts reported by caregivers include increased minor illnesses, headaches, feeling physically exhausted, and reduced sleep.<sup>124</sup> The GSS data revealed that high-intensity caregivers reported more physiological impacts than low-intensity caregivers.<sup>125</sup> The 2012 GSS data found that caregivers reported more psychological impacts if they were caring for spouses or children, followed by those caring for parents.<sup>126</sup>

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<sup>118</sup> Brewer, *ibid* at 227.

<sup>119</sup> Lee, *supra* note 7 at 30.

<sup>120</sup> Lee, *ibid* at 30-31, Williams, *supra* note 14 at 8; BCLI, *supra* note 3 at 1; CIHI, Dementia in Canada, *supra* note 33.

<sup>121</sup> Lee, *ibid* at 32; Williams, *ibid* at 8.

<sup>122</sup> McMaster Citizen Brief, *supra* note 10 at 8-9; CIHI, Dementia in Canada, *ibid*.

<sup>123</sup> Pyper, *supra* note 10 at 6; CIHI, Dementia in Canada, *ibid*.

<sup>124</sup> Lee, *supra* note 7 at 30-31; Williams, *supra* note 14 at 8; BCLI, *supra* note 3 at 1.

<sup>125</sup> Williams, *ibid* at 8; Sinha, *supra* note 1 at 13-14.

<sup>126</sup> Canada, Statistics Canada, *Family Caregiving: What are the Consequences?* By Martin Turcotte, Catalogue No 75-006-X (Ottawa: Statistics Canada, September 2013) [Turcotte, Family Caregiving] at 5.

There are some positive impacts reported by caregivers associated with caring for their family and friends. For example, data from the GSS found that 70% of caregivers reported good life satisfaction, and most of the caregivers who were employed found they had an appropriate balance between paid work and care work.<sup>127</sup> Caregivers experience fewer impacts if they have support from others, and have care support from the formal health care system.<sup>128</sup> Women in the CCEL Dialogue Project felt that care work contributed to a sense of purpose or meaning.<sup>129</sup>

Informal caregivers are frequently balancing both paid work and care work, so the impacts of care work on their employment are important. The 2012 GSS found that 60% of caregivers were employed.<sup>130</sup> The survey also found that the employment impacts increased with the amount of care work performed each week.<sup>131</sup> Employment impacts were more significant if caring for a spouse of any age.<sup>132</sup> Lilly, Laporte and Coyte found that higher caregiving intensity led to decreases in caregivers engaging in the paid workforce.<sup>133</sup> Employment impacts are wide ranging, including minor impacts such as having to take hours or days off.<sup>134</sup> Caregivers may also have to change their employment to have more time for caregiving responsibilities, such as changing jobs to one with fewer hours, more flexible hours, or where they can work from home.<sup>135</sup> Caregivers may also miss out on promotions or other opportunities.<sup>136</sup> Women may have to take leaves, vacation, or sick time in order to fulfill caregiving duties.<sup>137</sup> These impacts mean that women may have lower incomes due to their care work taking time away from paid employment.<sup>138</sup> Other economic impacts also flow from care work, such as aiding an older relative in paying for private or government care.<sup>139</sup>

Flowing from the impacts on informal caregiver's employment, these caregivers experience impacts on their financial situation in retirement and decisions about retirement.

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<sup>127</sup> Pyper, *supra* note 10 at 12; William, *supra* note 14 at 7; Sinha, *supra* note 1 at 13-15.

<sup>128</sup> Lee, *supra* note 7 at 31.

<sup>129</sup> Canadian Center for Elder Law, *Your Words are Worth Something: Identifying Barriers to the Well Being of Older Women*, CCEL Report No 6 (September 2013) [CCEL Dialogue Project] at 31.

<sup>130</sup> Sinha, *supra* note 1 at 14; Pyper, *supra* note 10 at 5.

<sup>131</sup> Pyper, *ibid* at 7.

<sup>132</sup> Turcotte, Family Caregiving, *supra* note 126 at 6-7.

<sup>133</sup> Meredith B Lilly, Audrey Laporte, & Peter C Coyte, "Do they care too much to work? The influence of caregiving intensity on the labour force participation of unpaid caregivers in Canada" (2010) 29 *Journal of Health Economics* 895 at 902.

<sup>134</sup> Lee, *supra* note 7 at 32; Williams, *supra* note 14 at 7; BCLI, *supra* note 3 at 13, 24.

<sup>135</sup> Lee, *ibid* at 32; Williams, *ibid* at 7, 8; BCLI, *ibid* at 13, 64.

<sup>136</sup> Lee, *ibid* at 32.

<sup>137</sup> Lee, *ibid* at 32; BCLI, *supra* note 3 at 24.

<sup>138</sup> CCEL Dialogue Project, *supra* note 129 at 7; Williams, *supra* note 14 at 7, 8; BCLI, *ibid* at 64.

<sup>139</sup> CCEL Dialogue Project, *ibid* at 30.

These retirement impacts may be due to both childcare and eldercare.<sup>140</sup> Employed caregivers do retire early to provide care to relatives.<sup>141</sup> Women are more likely to retire for care work than men.<sup>142</sup> The other impacts on women's employment such as fewer career advancements, changing jobs, or taking time off, lead to reduced pensions upon retirement.<sup>143</sup> Reduced pension amounts mean women are more likely to be living in poverty in old age.<sup>144</sup>

Income security in retirement is of greater concern to women who are divorced or separated.<sup>145</sup> In the CCEL Dialogue Project, female caregivers reported being concerned that they will not have enough money when they are older to pay for their own care.<sup>146</sup> Women who retired due to caregiving responsibilities reported lower life satisfaction ratings.<sup>147</sup> Reduced pension entitlements are also of more concern to women because they tend to live longer, and thus need more retirement savings.<sup>148</sup>

Women are already at a disadvantage in terms of pension entitlements and employment income because they are more likely to work in non-standard, precarious, or part-time employment, and are less likely to be a member of a union.<sup>149</sup> The Old Age Security (OAS) and Guaranteed Income Supplement (GIS) are available for low-income Canadians, including women, and they do rely on these income sources more than men.<sup>150</sup> However, these amounts are not enough to allow women to move out of poverty.<sup>151</sup> Women who have sufficient employment income can contribute to a Registered Retirement Savings Plan (RRSP), or may have an

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<sup>140</sup> Report of the Standing Committee, *supra* note 96 at 3.

<sup>141</sup> Pyper, *supra* note 10 at 13; McDonald, *supra* note 7 at 149-150; Report of the Standing Committee, *ibid* at 20.

<sup>142</sup> Pyper, *ibid* at 13; McDonald, *ibid* at 149-150

<sup>143</sup> Lee, *supra* note 7 at 32; CCEL Dialogue Project, *supra* note 129 at 28, 30; Report of the Standing Committee, *ibid* at 3, 9; BCLI, *supra* note 3 at 88.

<sup>144</sup> Lee, *ibid* at 32; McDonald, *supra* note 7 at 150.

<sup>145</sup> CCEL Dialogue Project, *supra* note 129 at 30.

<sup>146</sup> CCEL Dialogue Project *ibid* at 7.

<sup>147</sup> Alan, Atalay, & Crossley, *supra* note 7 at 111.

<sup>148</sup> Report of the Standing Committee, *supra* note 96 at 7.

<sup>149</sup> McDonald, *supra* note 7 at 157; Kodar, 'Pension (In)Securities', *supra* note 68 at 93-94.

<sup>150</sup> Report of the Standing Committee, *supra* note 96 at 11-13; Kodar, 'Pension (In)Securities', *ibid* at 96; BCLI, *supra* note 3 at 89-90

<sup>151</sup> McDonald, *supra* note 7 at 158; Kodar, 'Pension (In)Securities', *supra* note 68 at 96. For a single individual, receiving the OAS and GIS each month would give you \$17,642.40 per year. The low-income cut-offs range from \$17,175 to \$24,949 depending on the population of where the individual is residing. These payments would leave a person at or below the low-income cut-offs. (Canada, "Old Age Security payment amounts", online: <[www.canada.ca/en/services/benefits/publicpensions/cpp/old-age-security/payments.html](http://www.canada.ca/en/services/benefits/publicpensions/cpp/old-age-security/payments.html)>; Canada, "Low income cutoffs", online: <[www.canada.ca/en/employment-social-development/services/foreign-workers/caregiver/financial-ability.html](http://www.canada.ca/en/employment-social-development/services/foreign-workers/caregiver/financial-ability.html)>)

employer sponsored pension plan if their employer has one.<sup>152</sup> The Canada Pension Plan (CPP) does provide women who were employed a pension in retirement through contributions made during their employment.<sup>153</sup> However, this benefit may not be sufficient to give women retirement security.<sup>154</sup> Women often take time out of paid work to care for children and other family members and have lower incomes than men, so this leads to receiving a lower CPP amount.<sup>155</sup>

### **International Models for Reform**

Other countries such as Australia, France, Germany, Norway, and the United Kingdom have greater caregiver supports than those which currently exist in Canada.<sup>156</sup> This thesis compares the legal treatment of informal caregivers of the elderly in Canada with that of Australia. Australia was chosen because of its similar legal system and socio-economic conditions.<sup>157</sup> I examine reforms which look at all types of caregivers, including those who are in paid employment and those who are not, but focus only on issues of informal care of the elderly. The comparative analysis is used to develop policy implications for possible elder care reforms in Canada.

Australia has a similar structure to Canada in how the formal health care system provides care for the elderly, with the exception of also having a private system<sup>158</sup>, which aids in the analysis of elder care supports. Elders can receive in-home care which includes professional services, personal care, minor home maintenance and cleaning, and instrumental help such as transportation.<sup>159</sup> Once Australian elders are not able to live at home independently they may live in an aged care home which provides continuous nursing and personal care.<sup>160</sup>

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<sup>152</sup> Kodar, 'Pension (In)Securities', *ibid* at 98-99; BCLI, *supra* note 3 at 90-91

<sup>153</sup> McDonald, *supra* note 7 at 158; Report of the Standing Committee, *supra* note 96 at 15-17; Kodar, 'Pension (In)Securities', *ibid* at 96-97; BCLI, *ibid* at 90.

<sup>154</sup> McDonald, *ibid* at 158. The maximum CPP amount is \$1,134.17 per month, although the average is \$ 691.93 per month (Canada, "Canada Pension Plan" online: < [www.canada.ca/en/services/benefits/publicpensions/cpp/cpp-benefit/amount.html](http://www.canada.ca/en/services/benefits/publicpensions/cpp/cpp-benefit/amount.html)> at "how much could you receive")

<sup>155</sup> Report of the Standing Committee, *supra* note 96 at 16-17; Kodar, 'Pension (In)Securities', *supra* note 68 at 97.

<sup>156</sup> BCLI, *supra* note 3 at 94-96; Report of the Standing Committee, *ibid* at 18; Kodar, Pension (In)Securities, *ibid* at 100; Keefe & Fancey, *supra* note 22 at 20-21.

<sup>157</sup> See the thesis methodology chapter for a more detailed description of the reason Australia was chosen.

<sup>158</sup> Australian Government, "Health", online: < [www.australia.gov.au/information-and-services/health](http://www.australia.gov.au/information-and-services/health)> [Australia Health Services]; New South Wales Government, "The Australian Healthcare System", online: < [www.heti.nsw.gov.au/international-medical-graduate/australian-healthcare-system/](http://www.heti.nsw.gov.au/international-medical-graduate/australian-healthcare-system/)> [NSW Health System].

<sup>159</sup> Australian Government, "My Aged Care", online: <[www.myagedcare.gov.au/](http://www.myagedcare.gov.au/)> [My Aged Care Website] at Help at Home.

<sup>160</sup> *Aged Care Act 1997* (Cth) [ACA] s 21-2; *Approval of Care Recipients Principles 2014 (ACRP)* s 6; My Aged Care Website, *ibid* at Aging Care Homes.



## *Types and Hours of Informal Care Work in Australia*

The 2012 Australian Bureau of Statistics (ABS) survey found that in Australia there were approximately 2.7 million people caring for others who are elderly, disabled, or suffering from another health condition.<sup>161</sup> These carers represented 12% of the population.<sup>162</sup> Almost a third of carers are the primary carer of the recipient.<sup>163</sup> Women form the majority of all carers in Australia, and of primary carers.<sup>164</sup> The largest age group for carers is 45-64, and the likelihood of being a carer increases with age.<sup>165</sup> The ABS survey found that the majority of primary carers lived with the care recipient.<sup>166</sup> Care recipients are most commonly the spouse of the caregiver, especially among co-resident caregivers; carers who live apart are most commonly caring for a parent.<sup>167</sup> The ABS survey found that a third of carers provided 40 hours or more of care work a week.<sup>168</sup> Women are more likely to be providing high hours of care work than men.<sup>169</sup> Just over half of all carers and two thirds of primary carers also live in homes with lower incomes, and few primary carers lived in high income homes.<sup>170</sup> Carers are less likely to have achieved an education level of a bachelor's degree or higher than the population.<sup>171</sup>

Among carers, 70.9% live with their care recipient, which is termed a co-resident carer.<sup>172</sup> Co-resident carers are most often female, most often a partner or parent of the care recipient, and of middle age.<sup>173</sup> Primary carers represent about 28% of all carers in Australia,

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<sup>161</sup> ABS, 2012 DAC Survey; Australian Bureau of Statistics, "44360. Caring in the Community, Australia, 2012" (2014), online:

<[www.abs.gov.au/AUSSTATS/abs@.nsf/Latestproducts/4436.0Main%20Features22012?opendoopendo&tabname=Summary&prodno=4436.0&issue=2012&num=&view=>](http://www.abs.gov.au/AUSSTATS/abs@.nsf/Latestproducts/4436.0Main%20Features22012?opendoopendo&tabname=Summary&prodno=4436.0&issue=2012&num=&view=>) [ABS, Caring in the Community].

<sup>162</sup> ABS, Caring in the Community, *ibid*; Australia Bureau of Statistics, "4430.0.10.001: Disability, Ageing and Carers, Australia: First Results, 2015" (2016)

<[www.abs.gov.au/ausstats/abs@.nsf/0/56C41FE7A67110C8CA257FA3001D080B?Opendocument](http://www.abs.gov.au/ausstats/abs@.nsf/0/56C41FE7A67110C8CA257FA3001D080B?Opendocument)> [ABS, 2015 DAC Survey]; Australia Bureau of Statistics, "4430.0: Disability, Ageing and Carers, Australia: Summary of Findings, 2012" (2013), online: <[www.abs.gov.au/ausstats/abs@.nsf/mf/4430.0](http://www.abs.gov.au/ausstats/abs@.nsf/mf/4430.0)> [ABS, 2012 DAC Survey].

<sup>163</sup> ABS, 2012 DAC Survey, *ibid*; ABS, Caring in the Community, *ibid*.

<sup>164</sup> ABS, 2012 DAC Survey, *ibid*; ABS, Caring in the Community, *ibid*; Patricia Kenny, Madeline T King, & Jane Hall, "The Physical Functioning and Mental Health of Informal Carers: Evidence of Care-giving Impacts from an Australian Population-Based Cohort" (2014) 22:6 Health and Social Care in the Community 646 at 651.

<sup>165</sup> ABS, 2012 DAC Survey, *ibid*; ABS, Caring in the Community, *ibid*; Kenny et al., *ibid* at 651.

<sup>166</sup> ABS, 2012 DAC Survey, *ibid*.

<sup>167</sup> ABS, 2012 DAC Survey, *ibid*; ABS, Caring in the Community, *supra* note 161.

<sup>168</sup> ABS, 2012 DAC Survey, *ibid*.

<sup>169</sup> ABS, 2012 DAC Survey, *ibid*.

<sup>170</sup> ABS, 2012 DAC Survey, *ibid*.

<sup>171</sup> ABS, Caring in the Community, *supra* note 161.

<sup>172</sup> ABS, Caring in the Community, *ibid*.

<sup>173</sup> ABS, Caring in the Community, *ibid*.

and are predominantly female.<sup>174</sup> These carers usually provide a significant number of hours of care work – 40% provide at least 40 hours, and 20% provide at least 20 hours.<sup>175</sup>

Deloitte Access Economics and Carers Australia conducted an analysis of how much informal care work is worth economically in Australia in 2015 and projected informal care work in the future.<sup>176</sup> The study used the replacement cost value of care work within the formal sector.<sup>177</sup> Access Economics valued informal care work in Australia at \$60.3 billion, or 3.8% of the GDP.<sup>178</sup> The study compared the GDP percentage to similar studies in other countries, and found Australia was in the middle, with Canada being on the lower end at around 1.9% of Canada's GDP, and the United Kingdom at the higher end with 7.4% of its GDP.<sup>179</sup> In looking into the future, the study concluded that informal care work would become increasingly needed in the future, but the supply of informal caregivers would be decreasing, due to demographic changes such as an increase in the number of seniors in the population, lower fertility rates, and increases in labour force participation.<sup>180</sup> The deinstitutionalisation of care in Australia is also increasing the need for informal care.<sup>181</sup>

### *Care Work Impacts*

The ABS survey found that half of primary carers experienced psychological or physiological impacts due to their caring.<sup>182</sup> Carers have reported experiencing a variety of emotional impacts, including feeling angry, depressed, or anxious.<sup>183</sup> Reported physiological

<sup>174</sup> ABS, Caring in the Community, *ibid*.

<sup>175</sup> ABS, Caring in the Community, *ibid*.

<sup>176</sup> Deloitte Access Economics & Carers Australia, *The Economic Value of Informal Care in Australia in 2015*, (June 2015) [Access Economics] at 1.

<sup>177</sup> Access Economics, *ibid* at 14.

<sup>178</sup> Access Economics, *ibid* at 15, 16.

<sup>179</sup> Access Economics, *ibid* at 17-18.

<sup>180</sup> Access Economics, *ibid* at 20-21, 25-27.

<sup>181</sup> Access Economics, *ibid* at 27.

<sup>182</sup> ABS, Caring in the Community, *supra* note 161.

<sup>183</sup> ABC, Caring in the Community, *ibid*; Julie Ratcliff et al., "An Assessment of the Relationship Between Informal Caregiving and Quality of Life in Older Community-Dwelling Adults – More Positives than Negatives?" (2013) 21:1 Health and Social Care in the Community 35 at 36; Gillian Stockwell-Smith, Ursula Kellet, & Wendy Moyle, "Why Carers of Frail Older People are not Using Available Respite Services: an Australian Study" (2010) 19 Journal of Clinical Nursing 2057 at 2059; Peter Butterworth et al., "Factors that Explain the Poorer Mental Health of Caregivers: Results from a Community Survey of Older Australians" (2010) 44 Australian and New Zealand Journal of Psychiatry 616 at 617; Samantha J McKenzie et al., "Is Use of Formal Community Services by Older Women Related to Changes in their Informal Care Arrangements?" (2014) 34 Ageing & Society 310 at 311; Christina Aggar, Susan Ronaldson & Ian D Cameron, "Reactions to Caregiving of Frail, Older Persons Predict Depression" (2010) 19 International Journal of Mental Health Nursing 409 at 410, 411; Julie F Pallant & Carol Reid, "Measuring the Positive and Negative Aspects of the Caring Role in Community Versus Aged Care Setting" (2014) 33:4 Australian Journal on Ageing 244 at 244.



impacts include losing sleep, increased illnesses, exhaustion, and reduced exercise.<sup>184</sup> Carers of those with cognitive impairments such as Alzheimer's disease experience higher psychological and physiological impacts than those caring for someone with just physical impairments.<sup>185</sup> Both physiological and psychological impacts are greater where carers are providing a great number of hours of care work each week, or caring while in paid work.<sup>186</sup> Carer burden was found whether the care recipient was residing in the community or in residential care.<sup>187</sup>

The ABS survey found that while most carers were still able to engage in social activities outside the home, and most did so without their care recipients, caring still had an impact on their ability to participate in social activities.<sup>188</sup> Carers providing a significant number of hours of care work were less likely to be able to participate in social activities than those providing moderate hours of care work.<sup>189</sup> These trends held the same for carers participating in physical activity or cultural activities.<sup>190</sup> Care work can have both positive and negative impacts on relationships – studies have found that carers are mixed in whether they find their care role has harmed or helped their relationship with the care recipient.<sup>191</sup> Most primary carers report not having difficulty maintaining their outside social relationships, but 22% report difficulty in maintaining relationships. A study by Ratcliff et al. found that carers scored similar to non-carers in ratings of their social life.<sup>192</sup> This study also found that carers reported high feelings of independence, although the authors note this may have been due to carers scoring themselves in comparison to the care recipient.<sup>193</sup>

Research has shown carers experience some reduction in impacts through carer supports. For example, research has found that respite did help carers complete daily tasks, and lessen psychological and physiological impacts such as stress, while also benefiting their care

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<sup>184</sup> ABS, *Caring in the Community*, *ibid*; Stockwell-Smith et al, *ibid* at 2059; McKenzie et al, *ibid*, at 311; Pallant & Reid, *ibid* at 244.

<sup>185</sup> Ratcliff et al, *supra* note 183 at 36; Leigh Tooth et al., "Impact of Cognitive and Physical Impairment on Carer Burden and Quality of Life" (2008) 17 *Quality of Life Research* 267 at 272.

<sup>186</sup> Kenny et al, *supra* note 164 at 656, 657; Butterworth et al, *supra* note 183 at 619; McKenzie et al, *supra* note 183 at 311.

<sup>187</sup> Pallant and Reid, *supra* note 183 at 247.

<sup>188</sup> ABS, 2012 DAC Survey, *supra* note 162.

<sup>189</sup> ABS, 2012 DAC Survey, *ibid*.

<sup>190</sup> ABS, 2012 DAC Survey, *ibid*.

<sup>191</sup> ABS, *Caring in the Community*, *supra* note 161; Cathy Hales, "Crisis or commotion? An objective look at evidence on caregiving in families" (2007) 76 *Family Matters* 18 at 21.

<sup>192</sup> Ratcliff et al, *supra* note 183 at 44.

<sup>193</sup> Ratcliff et al, *ibid* at 44.

recipient.<sup>194</sup> Therapy or counselling can reduce the emotional impacts on carers and increase caring skills.<sup>195</sup> Non-formal care factors can also reduce caregiver impacts, such as having a support system.<sup>196</sup> Studies have found that carers are able to feel a sense of value or an increase in self-esteem through their caring role.<sup>197</sup> Feeling a sense of reciprocity within the caring relationship can also lessen the burdens that carers feel, such as the care recipient expressing love to the caregiver.<sup>198</sup>

Carers are less likely to be employed than the general population; the ABS survey found that only 42% of carers were employed.<sup>199</sup> Employment rates decreased with the amount of hours that the carer spent caring.<sup>200</sup> Among primary carers, women had lower employment rates than men.<sup>201</sup> The ABS survey notes that this lower labour force participation rate may be partially due to the fact that carers are more likely to be older.<sup>202</sup>

Employment impacts include reduced income, taking time off, or having to stop paid work.<sup>203</sup> Carers also experience retirement impacts such as having less retirement savings.<sup>204</sup> Just over half of primary carers relied mainly on government payments.<sup>205</sup> The ABS survey found that 17% of carers had lost employment income due to caring responsibilities, and about a third of carers had to take time off paid work.<sup>206</sup> Employment impacts increase with the number

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<sup>194</sup> Beverly O'Connell et al., "Carers' Perspectives of Respite Care in Australia: An Evaluative Study" (2012) 41:1 Contemporary Nurse 111 at 115; Kathryn Williams & Alan Owen, "A contribution to research and development in the carer support sector" (2009) 82 Family Matters 38 at 40.

<sup>195</sup> Williams & Owen, *ibid.*, at 40.

<sup>196</sup> Butterworth et al, *supra* note 183 at 622; Hales, *supra* note 191 at 21.

<sup>197</sup> Ratcliff et al, *supra* note 183 at 42; Aggar et al, *supra* note 183 at 411; Pallant & Reid, *supra* note 183 at 248.

<sup>198</sup> Catherine E Reid, Simon Moss, & Graeme Hyman, "Caregiver Reciprocity: The Effect of Reciprocity, Carer Self-Esteem and Motivation on the Experience of Caregiver Burden" (2005) 57:3 Australian Journal of Psychology 186 at 186-187, 192.

<sup>199</sup> Kenny et al, *supra* note 163 at 651; Joan Hughes, "Caring for carers: The financial strain of caregiving" (2007) 76 Family Matters 32 at 33; Ha Trong Nguyen & Luke Brian Connelly, "The Effect of Unpaid Caregiving Intensity on Labour Force Participation: Results from a Multinomial Endogenous Treatment Model" (2014) 100 Social Science & Medicine 115 at 116, 120; ABS, Caring in the Community, *supra* note 161; ABS, 2012 DAC Survey, *supra* note 162.

<sup>200</sup> ABS, 2012 DAC Survey, *ibid.*

<sup>201</sup> ABS, 2012 DAC Survey, *ibid.*; ABS, Caring in the Community, *supra* note 161.

<sup>202</sup> ABS, 2012 DAC Survey, *ibid.*

<sup>203</sup> ABS, Caring in the Community, *supra* note 161; Michael D Fine, "Employment and Informal Care: Sustaining Paid Work and Caregiving in the Community and Home-based Care" (2012) 37 Ageing International 57 at 62; Hughes, *supra* note 198 at 32; Hales, *supra* note 190 at 19; Trisha Hill et al, "What kind of jobs help carers combine care and employment?" (2008) 80 Family Matters 27 at 27, 28.

<sup>204</sup> Hughes, *ibid.*, at 33.

<sup>205</sup> ABS, Caring in the Community, *supra* note 161.

<sup>206</sup> ABS, Caring in the Community, *ibid.*

of hours of care work provided per week.<sup>207</sup> Being a co-resident carer also leads to lower employment rates.<sup>208</sup> Financial impacts are lessened for caregivers who have a higher household income or an employed spouse.<sup>209</sup> Workplaces vary significantly in whether and what kind of flexible work they offer, but the most common is allowing employees to work part-time.<sup>210</sup>

### Conclusion

This chapter has examined informal care work in Canada and Australia. Informal care work is very common in Canada and caregivers perform a wide range of caring activities.<sup>211</sup> Women perform a significant portion of this care work and experience more impacts from care work as women perform more intensive care work and more personal and medical care than men.<sup>212</sup> Caregivers experience many impacts from care work ranging from emotional and physical impacts such as experiencing depression and increased illnesses, to financial impacts such as the caregivers' reduced ability to engage in paid employment and save for retirement.<sup>213</sup> While this chapter examined the statistical data on care work, the next chapter examines the academic literature on care work in the areas of social science and law. The prevalence and impacts of care work are similar in Australia, where there are more caregiver supports.<sup>214</sup>

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<sup>207</sup> ABS, Caring in the Community, *ibid*; Nguyen & Connelly, *supra* note 199 at 116; Hill et al, *supra* note 201 at 28-29.

<sup>208</sup> Nguyen & Connelly, *ibid* at 120.

<sup>209</sup> Hill et al, *supra* note 201 at 27.

<sup>210</sup> Hill et al, *ibid* at 29-30.

<sup>211</sup> Sinha, *supra* note 1; Armstrong & Kits, *supra* note 6; BCLI, *supra* note 3.

<sup>212</sup> Kodar, Pension (In)Securities, *supra* note 68; Sinha, *supra* note 1; Pyper, *supra* note 10; Morris, *supra* note 68.

<sup>213</sup> Lee, *supra* note 7; BCLI, *supra* note 3; Williams, *supra* note 14; Report of the Standing Committee, *supra* note 96.

<sup>214</sup> BCLI, *supra* note 3; ABS, Caring in the Community, *supra* note 161.

## CHAPTER TWO: REVIEW OF THE INFORMAL CARE WORK AND RELATIONAL AUTONOMY LITERATURE

This chapter outlines the literature in the area of care work and relational theory. First, I examine social science discussions of informal care work and the assumptions in the literature. These discussions include the political and economic background in which care exists, and feminist considerations of elder care. Second, I examine the legal literature on informal care work in Canada and Australia. Third, I outline relational theory and the literature. Specifically, I describe relational autonomy and its applications to health care and unpaid care work, which is used in later chapters to analyze Australia and Canada's informal caregiving laws and make policy recommendations for future reforms in Canada.

### **Social Science Discussions of Care Work in Canada**

#### *Political Discussions of Unpaid Care Work in Canada*

The political setting in which unpaid care work takes place informs the public perception of and the legal treatment of caregivers. The dominant political ideology within Canada has changed significantly over the past several decades, and so has the state's treatment of women and care work.<sup>215</sup> The liberal welfare state emerged out of World War II, focusing on the government providing social security and promoting equality.<sup>216</sup> Janine Brodie described how, despite the equality goals of the welfare state, social security was provided through ensuring the male breadwinner was able to provide for the family, and women were only recognized as a wife or mother who needed to be supported by either their spouse or the government.<sup>217</sup>

Neo-liberalism began to emerge in the 1980s, and is now the dominant political discourse in Canadian politics.<sup>218</sup> Neo-liberalism espouses a government which is as minimal as possible in regulating the economy and its citizens, preferring to let the market govern itself, in theory.<sup>219</sup> Additionally, neo-liberalism entails a smaller social security system, viewing the citizen as an

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<sup>215</sup> Janine Brodie, "We Are All Equal Now" (2008) 9:2 Feminist Theory 145.

<sup>216</sup> Brodie, *ibid* at 150-151.

<sup>217</sup> Brodie, *ibid* at 150-151.

<sup>218</sup> Brodie, *ibid* at 154, 148-149.

<sup>219</sup> Brodie, *ibid* at 148, 154; Stephen Gill & Isabella Bakker, "New Constitutionalism and the Social Reproduction of Caring Institutions" (2006) 27 Theoretical Medicine and Bioethics 35 at 38, 51.

individual market actor who is to manage the ups and downs of the economy.<sup>220</sup>

Brodie argues that with the rise of neo-liberalism, gender equality has become a lesser part of the political discourse compared to when the women's movement was more powerful in the 1970s and 1980s, as well as being removed from the federal government's policy and structure.<sup>221</sup> For example, funding for gender-based groups has been dramatically reduced and the government's women's agencies were moved into the heritage portfolio, becoming special interest groups.<sup>222</sup> However, Brodie notes that this removal of gender equality from the neo-liberal political agenda is problematic because gender equality has not yet been achieved, and neo-liberalism's reliance on markets to govern the economy has a disproportionate effect on women.<sup>223</sup>

Neo-liberalism has led to decreased security for people, and has a negative impact on caring activities.<sup>224</sup> Gill and Bakker argue that this increased insecurity comes from the fact that market forces redistribute income to the richer, there is an increase in precarious employment especially for women, and the market on its own fails to allow for social development to progress.<sup>225</sup> Health care itself has become increasingly determined by monetary concerns and individuals are being left to care for themselves and their families.<sup>226</sup> The political and economic focus on the broader market is a concern in the care arena because care work is social and focused on the local community.<sup>227</sup> Vulnerable groups such as women and the elderly are most harmed by these cutbacks.<sup>228</sup> Isabella Bakker argues that these neo-liberal policies are based on a male bias, assuming that women are able to take up this care work within the home.<sup>229</sup>

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<sup>220</sup> Brodie, *ibid* at 148, 154; Gill & Bakker, *ibid* at 50.

<sup>221</sup> Brodie, *supra* note 215 at 154-157.

<sup>222</sup> Brodie, *ibid* at 154-157. The Federal Government's 2017 and 2018 budgets have included a gender analysis; the 2018 budget is proposing to invest \$100 million into women's groups in the country to change social norms (Canada, Department of Finance Canada, *Building a Stronger Middle Class, #Budget 2017*, Tabled in the House of Commons by the Honourable William Francis Morneau, PC, MP, Minister of Finance, March 22, 2017 (Ottawa: Department of Finance, 2017); Canada, Department of Finance Canada, *Equality + Growth, A Stronger Middle Class*, Tabled in the House of Commons by the Honourable William Francis Morneau, PC, MP, Minister of Finance, February 27, 2018 (Ottawa: Department of Finance, 2018).) In time, we may see these conclusions are different, but it is too early to determine whether this focus on gender will lead to any changes.

<sup>223</sup> Brodie, *ibid* at 145-148.

<sup>224</sup> Gill & Bakker, *supra* note 219 at 35-36.

<sup>225</sup> Gill & Bakker, *ibid* at 35-36, 51.

<sup>226</sup> Gill & Bakker, *ibid* at 37-38.

<sup>227</sup> Gill & Bakker, *ibid* at 41.

<sup>228</sup> Gill & Bakker, *ibid* at 42; Bakker, Isabella & Rachel Silvey, eds. *RIPE Series in Global Political Economy: Beyond States and Markets: The Challenges of Social Reproduction* (Florence KY USA: Routledge 2012) at 24.

<sup>229</sup> Isabella Bakker, "Social Reproduction and the Constitution of a Gendered Political Economy" (2007) 12: 4 *New Political Economy* 541 [Bakker, 'Social Reproduction and the Constitution'] at 546.

The structure for elder care is also built on an assumption of a strict divide between the public and private spheres.<sup>230</sup> Armstrong and Armstrong demonstrate that during the welfare state era, the government tried to create a clear distinction between the public and economic arenas in which the government was active, and the private arena in which the government was not active.<sup>231</sup> However this divide is not a true one. Care work that is both unpaid and paid happens within the home, and the care work that is done for pay and that which is done unpaid is similar.<sup>232</sup> Increasingly, care is being taken away from the public sector and moved to the private sector, and this restructuring is making the division less clear between the public and the private sphere.<sup>233</sup>

#### *Feminist Considerations of Elder Care Law*

Nancy Guberman made several suggestions for reforming informal care work in a way that would be less detrimental to women's interests. She argues that there needs to be a genuine choice for women in whether they care for their relatives.<sup>234</sup> Currently, "choices in ... caregiving arrangements are always dependent on one's social conditions, economic status, knowledge of available resources..."<sup>235</sup> Guberman argues that for care choices to be equal choices, "these options must be of equal social value..."<sup>236</sup> and there must be a variety of quality choices that are culturally appropriate.<sup>237</sup> Care should be considered a valuable form of work.<sup>238</sup> The public health care system should be the core of health care.<sup>239</sup> If family members make the genuine choice to care, they should not experience negative impacts from doing so.<sup>240</sup>

Armstrong and Armstrong consider how to study care work, given its gendered nature. They take as an assumption, following the socialization literature, that while women give birth, there is no biological basis for women doing the majority of care work.<sup>241</sup> It is the social and political structure in which people are embedded which influences the behaviors each sex

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<sup>230</sup> Armstrong & Armstrong, *supra* note 5 at 25; Aronson & Neysmith, *supra* note 53 at 37-38.

<sup>231</sup> Armstrong & Armstrong, *ibid* at 24-28.

<sup>232</sup> Armstrong & Armstrong, *ibid* at 27-28.

<sup>233</sup> Armstrong & Armstrong, *ibid* at 25-28.

<sup>234</sup> Guberman, *supra* note 5 at 83.

<sup>235</sup> Guberman, *ibid* at 83.

<sup>236</sup> Guberman, *ibid* at 83.

<sup>237</sup> Guberman, *ibid* at 83-84.

<sup>238</sup> Guberman, *ibid* at 82.

<sup>239</sup> Guberman, *ibid* at 82.

<sup>240</sup> Guberman, *ibid* at 82.

<sup>241</sup> Armstrong & Armstrong, *supra* note 5 at 9.

exhibits.<sup>242</sup> Because women do the majority of the caring, studying women as a whole is helpful because it can show what work is assigned by society to women and how society and law structures these gender relations.<sup>243</sup> However, it is equally important to look at the differences between women because these are significant when one takes into account factors like age, race, and location.<sup>244</sup> Looking at both the similarities and differences among women helps to develop a fuller picture of care work women do and develop stronger reforms to aid women.<sup>245</sup>

Armstrong and Armstrong suggest that to make care work more equal and less harmful to women, they need to be empowered.<sup>246</sup> This means giving women more choices in creating informal care work, including increased paid care services that can be obtained within the home.<sup>247</sup> Care work needs to be recognized as requiring significant skill which not all women automatically possess, and that these care skills are very valuable.<sup>248</sup> Society should also not assume that simply because a family member emotionally cares for a relative, they want to or have the skills to physically care for their relative.<sup>249</sup>

#### *Application to Research and Analysis*

This thesis assumes in its research and analysis that gender roles in care work are socially created, differ with each society, and are malleable over time. This thesis examines both countries' elder care work within the political and economic circumstances in which they exist. I agree with researchers that greater government provision of care services could reduce the need for informal elder care, and thus decrease the burden on caregivers. I assume in my thesis that families may still choose to take on caregiving responsibilities even in the event formal health care and community care services are increased. Thus, the choices to provide informal care work should be recognized, valued, and supported. This thesis analyzes informal elder care based on the assumption that informal care work will take place because many seniors will want to remain in their homes and community for as long as possible. Therefore, it is important to examine the supports for these informal caregivers, both from the government and the community and relations around them, due to the negative impacts care work has on caregivers.

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<sup>242</sup> Armstrong & Armstrong, *ibid* at 9.

<sup>243</sup> Armstrong & Armstrong, *ibid* at 6.

<sup>244</sup> Armstrong & Armstrong, *ibid* at 7-8.

<sup>245</sup> Armstrong & Armstrong, *ibid* at 5-8.

<sup>246</sup> Armstrong & Armstrong, *ibid* at 37.

<sup>247</sup> Armstrong & Armstrong, *ibid* at 37.

<sup>248</sup> Armstrong & Armstrong, *ibid* at 39-40.

<sup>249</sup> Armstrong & Armstrong, *ibid* at 40.



### *Instrument Choice by Government*

This section briefly outlines some basic information on what instruments governments have available to them to implement their desired policies and programs, although a full discussion of the large instrument choice literature is beyond the scope of this thesis.

Instruments refer to “...the range of instruments spanning law and regulation, subsidies and grants, organization and privatization, and information dissemination and taxation.”<sup>250</sup>

Government commonly use what are termed ‘command-and-control’ tools, which are statute and regulation.<sup>251</sup> The instrument choice literature has focused on this type of instrument.<sup>252</sup> This type of tool is used frequently in the context of health care.<sup>253</sup> Instruments can be substantive or procedural, or both – substantive instruments directly provide government services, while procedural instruments direct a process.<sup>254</sup> Procedural policy instruments, some of which may be useful in the context of caregiving, “...include education, training, instruction creation, the selective provision of information, formal evaluations, hearings, and institutional reform.”<sup>255</sup> Additional tools include creating interest groups or funding research.<sup>256</sup> Tools can also target markets or finances, such as using taxes.<sup>257</sup>

In theory, a multitude of policy instruments could be used to address a specific problem.<sup>258</sup> An example of how these different types of instrument choices could be used in the context of health care is given by Michael Howlett. He notes that

...a government seeking to promote health care for the population, for example, could leave it entirely to the family to provide health services, with the competence and availability of family members determining who gets how much and at what cost. Or the government might go to the other extreme and provide health services through its own administrative agency, paid for directly out of its general tax revenues, leaving no room for the market or other private organizations. In between the two extremes lie a range of other instruments, including exhorting the population to keep healthy, subsidizing those

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<sup>250</sup> Pearl Eliadis, Margaret M Hill, & Michael Howlett, “Introduction” in F Pearl Eliadis, Margaret M Hill, & Michael Howlett, eds., *Designing Government: from Instruments to Governance* (Montreal: McGill-Queen’s University Press, 2005) 3 at 4.

<sup>251</sup> Eliadis, Hill, & Howlett, *ibid* at 8; B Guy Peters & John A Hoornbeek, “The Problem of Policy Problems” in Eliadis, Hill, & Howlett, *supra* note 249, 77 at 80; Sarah Whiteford, “Beyond Instrument Choice: Micro-Level Policy Design in Manitoba’s Child Care System” (2015) 38 *Man LJ* 260 at 264-265.

<sup>252</sup> Eliadis, Hill, & Howlett, *ibid* at 8; Peters & Hoornbeek, *ibid* at 80; Whiteford, *ibid*.

<sup>253</sup> Whiteford, *ibid* at 272.

<sup>254</sup> Michael Howlett, “What is a Policy Instrument? Tools, Mixes, and Implementation Styles” in Eliadis, Hill, & Howlett, *supra* note 249 at 34.

<sup>255</sup> Howlett, *ibid* at 36; See also Peters & Hoornbeek, *supra* note 251 at 81-82.

<sup>256</sup> Howlett, *ibid* at 36-37.

<sup>257</sup> Peters & Hoornbeek, *supra* note 251 at 81-82.

<sup>258</sup> Howlett, *supra* note 254 at 33.



who are poor, and regulating doctors and hospitals – which could, in theory, equally well address health-care issues.<sup>259</sup>

Peters and Hoornbeek consider that some policy problems such as gender equality “...may not be as amenable to being addressed simply by spending money. Rather...some other form of government action, and perhaps broader societal changes, be implemented”<sup>260</sup>

The newer literature on instrument choice has shifted the focus from traditional command-and-control instruments and simple classification of what should be used, toward focusing on the need to ensure that the instrument specifically fits the problem and context in which it needs to address, and the need for using multiple types of instruments which can work together.<sup>261</sup> Peters and Hoornbeek argue that it is important in examining instrument choice to determine what the policy problem actually is.<sup>262</sup> Examining the context in which the instrument is meant to work is important because the context of the problem can influence whether the instrument will be able to accomplish its goals.<sup>263</sup> The effect of the instrument on all individuals must also be examined – Howlett notes, for example, that tax instruments may have different results for those in different socio-economic classes.<sup>264</sup> Using a mix of instruments can be important in addressing a policy problem because the problem may not be fully addressed by a singular policy instrument.<sup>265</sup> An example of a policy mix, as described by Whiteford, is the retirement benefits in the Manitoba child care regulations, which when it was created was meant to work as a comprehensive scheme, not a single piece of legislation.<sup>266</sup> Whiteford does also argue that, despite the focus on what instrument is chosen by government, the instrument choice scholars should also focus on micro-level policy, to examine what options are available to government in crafting within a specific policy tool.<sup>267</sup>

### **Canadian Legal Literature on Informal Care Work**

The legal analysis in Canada of informal care work has primarily examined how pensions

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<sup>259</sup> Howlett, *ibid* at 33-34.

<sup>260</sup> Peters & Hoornbeek, *supra* note 251 at 96.

<sup>261</sup> Eliadis, Hill, & Howlett, *supra* note 250 at 4-6; Howlett, *supra* note 254 at 31-33; Whiteford, *supra* note 251 at 262-264.

<sup>262</sup> Peters & Hoornbeek, *supra* note 251 at 82-85.

<sup>263</sup> Howlett, *supra* note 254 at 40-41; Whiteford, *supra* note 251 at 263.

<sup>264</sup> Howlett, *ibid* at 41.

<sup>265</sup> Howlett, *ibid* at 42.

<sup>266</sup> Whiteford, *supra* note 251 at 278. Whiteford explains that the regulations provides funds matching for child care worker's pension contributions to varied private and employment pension plans (at 274).

<sup>267</sup> Whiteford, *ibid* at 277-278.

are impacted by informal care work.<sup>268</sup> In analyzing possible legal reforms to better support informal caregivers in Canada, some authors have utilized an examination of what other countries have done to support informal caregivers.<sup>269</sup> This section examines the work by Canadian scholars seeking legal changes to better position women performing care work.<sup>270</sup>

The most comprehensive evaluation of informal care work for those caring for family members who are not children was a 2010 study paper done by the British Columbia Law Institute (BCLI).<sup>271</sup> This study was seeking to examine what laws in BC and federally are available to support balancing paid work and care work.<sup>272</sup> Family caregivers, for the purposes of this study, included those caring for “...aging parents, children with disabilities, and people coping with mental health issues, addictions and chronic illnesses.”<sup>273</sup> The BCLI examined what other countries have done in terms of employment leave, financial compensation, and workplace flexibility to better balance paid work and care work, noting that Canada did not have sufficient laws to help caregivers balance paid work, and the laws were not comprehensive enough or integrated enough.<sup>274</sup> A specific theoretical framework was not directly employed, but the study did note and use in its examination the ideas that care work is conducted by women more than men, that unpaid care is of value to society, that dependency is an important part of care, and relationships should be recognized.<sup>275</sup>

The goal of this study was to encourage government to undertake legal reforms to better

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<sup>268</sup> BCLI, *supra* note 3; Kodar, Pension (In)Securities, *supra* note 68; Freya Kodar, "Pensions and Unpaid Work: A Reflection on Four Decades of Feminist Debate" (2012) 24 Canadian Journal of Women and the Law 180 [Kodar, Pensions and Unpaid Work]; Faye L Woodman, "The Fiscal Equality of Women: Proposed Changes to Legislation Governing Private Pension Plans in Alberta, British Columbia, and Nova Scotia" (2010) 22 Canadian J Women & Law 129; Claire Yong, "Pensions, Privatization, and Poverty: The Gendered Impact" (2011) 23 Canadian Journal of Women & Law 661; Keefe & Fancey, *supra* note 22; Janice Keefe & Beth Rajnovich, "To Pay or Not to Pay: Examining Underlying Principles in the Debate on Financial Support for Family Caregivers" (2007) 26 Canadian Journal on Aging 77; Jenny Flagler & Weizhen Dong, "The Uncompassionate Elements of the Compassionate Care Benefits Program: A Critical Analysis" (2010) 17:1 Global Health Promotion 50.

<sup>269</sup> BCLI, *ibid*; Keefe & Fancey, *ibid*; Keefe & Rajnovich, *ibid*.

<sup>270</sup> This thesis will examine only suggested or existing programs directly aimed at aiding caregivers of the elderly. This will exclude programs such as a basic guaranteed income which are more general in nature, not aimed at caregivers. An example of this is the Ontario Basic Income Pilot which gives a payment to those making below a certain income threshold (Ontario, Ministry of Community and Social Services. "Ontario Basic Income Pilot", online: <[www.ontario.ca/page/ontario-basic-income-pilot](http://www.ontario.ca/page/ontario-basic-income-pilot)>). These widespread programs are beyond the scope of this analysis.

<sup>271</sup> BCLI, *supra* note 3.

<sup>272</sup> BCLI, *ibid* at 1-2.

<sup>273</sup> BCLI, *ibid* at 1.

<sup>274</sup> BCLI, *ibid* at 98-101, 106.

<sup>275</sup> BCLI, *ibid* at 3-9.

support paid work and care work for family caregivers in the province.<sup>276</sup> While some options were presented based on what was seen in other countries and what other scholars have suggested, there were no recommendations on which options should be chosen.<sup>277</sup> Options for reform for employment leave included an increased compassionate care benefit, such as what illnesses would trigger eligibility and the length of the leave.<sup>278</sup> Other workplace changes included requiring employers to consider flexible work arrangements and clarifying the human rights code provisions for family care.<sup>279</sup> Finance-related reforms included creating a better tax credit for those with lower incomes, giving direct payments to caregivers, and allowing pension drop-outs for family caregiving.<sup>280</sup> The BCLI also noted that for paid work and care work pressures to be alleviated, societal changes would likely be required, such as recognizing the value of care and not assuming care should be and is kept only in the private sphere.<sup>281</sup>

Pension reforms have been the target of many Canadian scholars. In examining the current Canadian pension schemes, many authors have noted that women are disadvantaged in terms of access to sufficient pensions due to the fact that women have to take more time out of the workforce to care for young children and other family members.<sup>282</sup> Women are more likely to be engaged in precarious employment, which is less likely to have workplace pensions or allow for private pension contribution.<sup>283</sup> Therefore, women predominantly are relying on the public pension pillars, such as Old Age Security (OAS), Guaranteed Income Supplement (GIS), and the Canada Pension Plan (CPP), which do not provide a sufficient income; women who are just relying on OAS and GIS would not be above the poverty line.<sup>284</sup> Woodman argues that in pension analysis, often the family is looked at as a whole economic unit, so women's needs are not visible.<sup>285</sup> Woodman and Yong both argue some pension forms assume women can rely on a spouse for retirement income, which reduces their autonomy, although Yong notes that this may

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<sup>276</sup> BCLI, *ibid* at 1-12.

<sup>277</sup> BCLI, *ibid* at 106-109.

<sup>278</sup> BCLI, *ibid* at 107.

<sup>279</sup> BCLI, *ibid* at 108.

<sup>280</sup> BCLI, *ibid* at 108.

<sup>281</sup> BCLI, *ibid* at 109-110.

<sup>282</sup> Kodar, Pension (In)Securities, *supra* note 68 at 94-96; Kodar, Pensions and Unpaid Work, *supra* note 268 at 181-182; Woodman, *supra* note 268 at 130-132, 135; Yong, *supra* note 268 at 661-664.

<sup>283</sup> Kodar, Pension (In)Securities, *ibid* at 93-95; Woodman, *ibid* at 132, 135; Yong, *ibid* at 663-665.

<sup>284</sup> Kodar, Pension (In)Securities, *ibid* at 96-99; Woodman, *ibid* at 132, 138; Yong, *ibid* at 667-668.

<sup>285</sup> Woodman, *ibid* at 132-133.

not always be the case with changing family forms.<sup>286</sup>

The pension literature features several recommendations for pension law reform to better allow for women to have sufficient pension income, given the gendered difference in pension entitlement and care work. For the OAS and GIS, suggestions include increasing the payment amount so that it would leave the recipient above the poverty line.<sup>287</sup> Suggestions for improving the CPP include increasing the CPP rate to at least 50% of the average earnings.<sup>288</sup> Improvements for Registered Pension Plans (RPP) include requiring employers to provide pensions to part-time employees as well as their full-time employees.<sup>289</sup> Yong suggests creating a new pension plan that those without a workplace pension would contribute to.<sup>290</sup>

Yong notes that in considering pension reform, the focus should not just be on improvements to the private pension pillars like Registered Retirement Savings Plans (RRSP), because the private system does not allow women to fully take advantage of it due to their lower incomes and time taken out of paid work to perform care work; the public tiers should also be strengthened.<sup>291</sup> Kodar notes that the above reforms may not adequately correct the gender imbalances in pension coverage due to the gendered nature of care work; to correct these differences fully, the gendered nature of unpaid care work needs to change and women's ability to engage in the workforce fully.<sup>292</sup>

Canadian scholars have also explored other financial options for supporting caregivers. Flagler and Dong examined the compassionate care benefit program under the Employment Insurance (EI) scheme, noting that the program could use some improvements, given the limited eligibility requirements tied to EI and the low amount of payment.<sup>293</sup> To improve the program and better support caregivers, the authors argue for increasing the amount of money provided by the program and expanding the eligibility criteria, to better support palliative patients and the important role their informal caregivers play.<sup>294</sup>

Keefe and Rajnovich examined the arguments for and against providing caregivers direct

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<sup>286</sup> Woodman, *ibid* at 132-133, 153; Yong, *supra* note 268 at 681.

<sup>287</sup> Kodar, Pension (In)Securities, *supra* note 68 at 99; Yong, *ibid* at 681.

<sup>288</sup> Kodar, Pension (In)Securities, *ibid* at 99; Yong, *ibid* at 682.

<sup>289</sup> Kodar, Pension (In)Securities, *ibid* at 99.

<sup>290</sup> Yong, *supra* note 268 at 683.

<sup>291</sup> Yong, *ibid* at 680.

<sup>292</sup> Kodar, Pension (In)Securities, *supra* note 68 at 100.

<sup>293</sup> Flagler & Dong, *supra* note 268 at 50, 54-55.

<sup>294</sup> Flagler & Dong, *ibid* at 56-57.

financial support such as caregiver payments, and they examine ones which are provided in other countries.<sup>295</sup> They note that the goals of financial payments in other countries include economic and social aspects; economic goals include reducing the health care costs on the government by encouraging informal care, and social goals include providing support and recognition to caregivers for their role.<sup>296</sup> Keefe and Rajnovich note that those opposed to financial payment programs may be concerned women may be pressured to stay home more to care if provided financial payments, and the gendered nature of care work may be enforced not lessened, and payments of low amounts do not help to change the gendered nature of care work or women's financial insecurity.<sup>297</sup> They note, however, that these payments would be 'gender justice', because it gives societal value to their care role and some temporary financial security so that women may begin to change their role and position in life, and not become stuck in their caregiving role.<sup>298</sup>

Martin examined what supports there are for family caregivers to balance paid work and care work.<sup>299</sup> The author notes that Canada is lacking in flexible work arrangements for those who are engaged in care work, with the only groups having significant flexible work arrangements being those with unions.<sup>300</sup> Martin argues that the government needs to require flexible work arrangements because most employers are not providing this voluntarily, and letting employers voluntarily provide better work-care policies to employees has not yet led to a better balance – paid work tends to predominate over care work in the workplace.<sup>301</sup>

### **Australian Legal Literature on Informal Care Work**

Australian scholars examining issues of informal care work have primarily focused on anti-discrimination legislation and its ability to challenge workplace and informal care norms.<sup>302</sup>

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<sup>295</sup> Keefe & Rajnovich, *supra* note 268.

<sup>296</sup> Keefe & Rajnovich, *ibid* at 82-83.

<sup>297</sup> Keefe & Rajnovich, *ibid* at 83-84.

<sup>298</sup> Keefe & Rajnovich, *ibid* at 84.

<sup>299</sup> Judith A Martin, "Brining a Critical Gender Lens to Work-Family Balance Issues in the Workplace" (2004) 67 Saskatchewan Law Review 507.

<sup>300</sup> Martin, *ibid* at 510-511.

<sup>301</sup> Martin, *ibid* at 510-511, 518-520.

<sup>302</sup> Anna Chapman, "Australian Anti-Discrimination Law, Work, Care and Family" Centre for Employment and Labour Relations Law, Melbourne School of Law (Jan 2012) Working Paper No 51 [Chapman, Anti-Discrimination Law]; Anna Chapman, "Industrial Law, Working Hours, and Work, Care and Family" (2010) 36:3 Monash University Law Review 190 [Chapman, Industrial Law]; Anna Chapman, "Reasonable Accommodation, Adverse Action and the Case of Deborah Schou" (2012) 33 Adelaide Law Review 39 [Chapman, Reasonable Accommodation]; Belinda Smith, "It's About Time – For a New Regulatory Approach to Equality" (2008) 36 Federal Law Review 117 [Smith, It's About Time]; Belinda Smith, "What Kind of Equality can we Expect from the

Authors in Australia have been focusing on the nature of paid work and care work, and how workplace and care norms have led to gender differences.<sup>303</sup> Workplace norms in Australia are based on a male model of work, assuming that a spouse is at home caring for the family so that the worker is able to spend all of his time devoted to paid work.<sup>304</sup> These male workplace norms did exist in the past, and are still present to this day, and cause problems for women attempting to balance paid work and care work.<sup>305</sup> Women have done and still do most of the unpaid care work.<sup>306</sup> Government policies and social norms assume that there is a public/private divide, where care work is done at home and does not interfere with paid work, but scholars argue this is illusory.<sup>307</sup> Care work is not valued by society in the context of these male norms.<sup>308</sup>

Many of the authors argue that the government needs to change its policies and views on paid work so that employment and care norms are not so detrimental to women.<sup>309</sup> This is based on an assumption that government does influence care and employment norms through policies and laws.<sup>310</sup> Smith argues that changes to workplace laws that would increase flexibility in paid work and care work would not automatically change norms, but would be a move in the right direction.<sup>311</sup> Smith argues that workplace legislation and academic discussions state that women

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Fair Work Act?” (2011) 35 Melbourne University Law Review 545 [Smith, Fair Work Act]; Belinda Smith, “Not the Baby and the Bathwater: Regulatory Reform for Equality Laws to Address Work-Family Conflict” (2006) 28 Sydney Law Review 689 [Smith, Baby with the Bathwater]; Barbara Pocock, Sara Charlesworth, & Janine Chapman, “Work-family and work-life pressures in Australia: advancing gender equality in “good times”?” (2013) 33 Int J of Sociology & Social Policy 594; Marian Baird, Sue Williamson, & Alexandra Heron, “Women, Work and Policy Setting in Australia in 2011” (2012) 54:3 Journal of Industrial Relations 326. Canadian literature has briefly discussed using anti-discrimination or human rights legislation to protect family caregivers, but this is very limited (see BCLI, *supra* note 3; Lucy Barylak & Nancy Guberman. Beyond Recognition – Caregiving & Human Rights in Canada: A Policy Brief (October 2016), online: <thecaregivernetwork.ca/event/violating-human-rights-family-caregivers/>; see Analysis). Canadian literature on family caregivers has tended to focus on using the pension system to bolster caregivers, as discussed in the previous section.

<sup>303</sup> Chapman, Anti-Discrimination Law, *ibid*; Smith, Baby with the Bathwater, *ibid*; Pocock, Charlesworth, & Chapman, *ibid*; Baird, Williamson, & Heron, *ibid*.

<sup>304</sup> Baird, Williamson, & Heron, *ibid* at 327-328; Smith, It’s About Time, *supra* note 302 at 120-122; Smith, Fair Work Act, *ibid* at 549; Smith, Baby and the Bathwater, *supra* note 302 at 690; Pocock, Charlesworth, & Chapman, *ibid* at 599.

<sup>305</sup> Baird, Williamson, & Heron, *ibid* at 328-329; Chapman, Anti-Discrimination Law, *supra* note 302 at 10-11; Chapman, Industrial Law, *ibid* at 190-193; Smith, Baby and the Bathwater, *ibid* at 690.

<sup>306</sup> Smith, Fair Work Act, *supra* note 302 at 548-549; Smith, Baby with the Bathwater, *supra* note 302 at 689-690; Pocock, Charlesworth, & Chapman, *supra* note 302 at 596.

<sup>307</sup> Baird, Williamson, & Heron, *ibid* at 328-329; Chapman, Anti-Discrimination Law, *ibid* at 13-14; Smith, It’s About Time, *supra* note 302 at 120-122; Smith, Baby with the Bathwater, *ibid* at 690.

<sup>308</sup> Baird, Williamson, & Heron, *ibid* at 329.

<sup>309</sup> Baird, Williamson, & Heron, *ibid* at 339; Smith, It’s About Time, *supra* note 302 at 122; Pocock, Charlesworth, & Chapman, *supra* note 302 at 608.

<sup>310</sup> Smith, Baby with the Bathwater, *supra* note 302 at 701.

<sup>311</sup> Smith, Baby with the Bathwater, *ibid* at 702.



can choose how to balance paid work and care work, but that women in reality do not have a choice as to engaging in care work or how to balance paid work and care work.<sup>312</sup> In examining anti-discrimination law, Chapman and Smith note that formal equality is used in discrimination claims utilizing an unencumbered worker as the comparator, which does not allow employment and gender norms of society to be challenged.<sup>313</sup>

In examining provisions allowing employees to request flexible work arrangements, authors note that despite the benefits of these provisions, there are few ways to enforce these provisions against an employer who does not provide them.<sup>314</sup> Chapman argues that provisions to protect employee's rights to flexible work arrangements may not be sufficient because they do not account for how workplaces actually function in terms of negotiating for different working conditions.<sup>315</sup> Smith notes that these provisions do not help caregivers who are working in jobs with less consistent hours and need more consistency to provide care at specific times.<sup>316</sup>

## Relational Autonomy

### *Relational Theory*

Relational theory posits that human beings are relational, and that individuals are constituted by the relationships they are in.<sup>317</sup> This is based on the assumption that humans are social in nature, and that our relationships shape who we are through several processes, including socialization.<sup>318</sup> Thus, relationships are central to our definition of self.<sup>319</sup> Relational theory asks in its analysis what the effect is of being in and constituted by relationships.<sup>320</sup> The relationships that shape individuals include not just intimate relationships like family and close friends, but

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<sup>312</sup> Smith, Baby with the Bathwater, *ibid* at 696-698.

<sup>313</sup> Chapman, Anti-Discrimination Law, *supra* note 302 at 18, 22-24; Smith, It's About Time, *supra* note 302 at 123-124, 129, 131-132; Smith, Fair Work Act, *supra* note 302 at 553, 554.

<sup>314</sup> Chapman, Reasonable Accommodation, *supra* note 302 at 50-51, 77-78; Smith, Fair Work Act, *supra* note 302 at 571; Pocock, Charlesworth, & Chapman, *supra* note 302 at 601.

<sup>315</sup> Chapman, Reasonable Accommodation, *ibid* at 50, 55.

<sup>316</sup> Smith, Fair Work Act, *supra* note 302 at 570-571.

<sup>317</sup> Jennifer Nedelsky, *Law's Relations: A Relational Theory of Self, Autonomy, and Law* (New York, NY: Oxford University Press, 2011) at 19-20; Robert Leckey, *Contextual Subjects: family, state and relational theory* (Toronto, ON: University of Toronto Press, 2008) at 7-8; Francoise Baylis, Nuala P Kenny, & Susan Sherwin, "A Relational Account of Public Health Ethics" (2008) 1:3 *Public Health Ethics* 196 at 202; Nuala P Kenny, Susan B Sherwin & Francoise E Baylis, "Re-visioning Public Health Ethics: A Relational Perspective" (2010) 10:1 *Can J Public Health* 9 at 10; Perkins et al., *supra* note 18 at 215.

<sup>318</sup> Jennifer J Llewellyn & Jocelyn Downie. "Introduction" in Jocelyn Downie & Jennifer J Llewellyn, eds., *Being Relational: Reflections on Relational Theory and Health Law* (Vancouver, British Columbia: UBC Press, 2012) 1 at 4-5; Leckey, *ibid* at 7-8.

<sup>319</sup> Llewellyn & Downie, *ibid* at 4-5; Perkins et al, *supra* note 18 at 215; Lucy Series, "Relationships, Autonomy and Legal Capacity: Mental Capacity and Support Paradigms" (2015) 40 *Int J Law & Psychiatry* 80 at 81.

<sup>320</sup> Llewellyn & Downie, *ibid* at 4; Perkins et al., *ibid* at 215.

extend to others such as teachers, the state, and the legal system.<sup>321</sup> Men and women are both constituted by relationships, but some gender differences in men and women are due to how the societal norms and those relations around them have shaped them to behave differently.<sup>322</sup> While it is core to relational theory that people are constituted by their relationships, it is important to note that relational theory does not assume that people are solely created by their relationships, but that people can express autonomy in who they are.<sup>323</sup> The roots of this theory lie in feminism, including the ethic of care.<sup>324</sup>

Because humans are so embedded within their relationships, these relationships have the ability to both help and hinder growth.<sup>325</sup> Importantly, not all relationships are good.<sup>326</sup> Relationships can harm a person's ability to expand their capacities to the fullest, such as not allowing a person to achieve full autonomy.<sup>327</sup> If individuals are in relationships that support them, these relationships enable them to grow and fulfill their capacities.<sup>328</sup> An example of the way relationships can hinder development is the gendered nature of care work leading to women being required to care, which will be discussed below.<sup>329</sup>

Nedelsky argues that relationships create societal norms, including gender norms, and relationships are in turn influenced by these societal norms.<sup>330</sup> This means that individuals both create norms and change existing norms through the choices they make.<sup>331</sup> If a whole community attempts to create a different pattern of gender norms, this community is more powerful than an individual on their own in trying to alter a societal norm.<sup>332</sup>

### *Relational Autonomy*

The relational conception of autonomy is significantly different than the liberal vision of

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<sup>321</sup> Nedelsky, *supra* note 317 at 19-20, 30-31; Leckey, *supra* note 317 at 8.

<sup>322</sup> Nedelsky, *ibid* at 32-33.

<sup>323</sup> Nedelsky, *ibid* at 31.

<sup>324</sup> Llewellyn & Downie, *supra* note 318 at 6.

<sup>325</sup> Nedelsky, *supra* note 317 at 22; Leckey, *supra* note 317 at 10-11; Susan B Boyd, "Autonomy for Mothers? Relational Theory and Parenting Apart" (2010) 18 Fem Leg Stud 137 at 139-141.

<sup>326</sup> Nedelsky, *ibid* at 31; Leckey, *ibid* at 10-11; Boyd, *ibid* at 139-141.

<sup>327</sup> Nedelsky, *ibid* at 28, 31-32; Leckey, *ibid* at 10-11; Boyd, *ibid* at 139-141.

<sup>328</sup> Nedelsky, *ibid* at 28-30; Leckey, *ibid* at 10-11; Boyd, *ibid* at 139-141.

<sup>329</sup> Nedelsky, *ibid* at 32.

<sup>330</sup> Nedelsky, *ibid* at 20.

<sup>331</sup> Nedelsky, *ibid* at 21.

<sup>332</sup> Nedelsky, *ibid* at 22.



autonomy.<sup>333</sup> Liberal theories view autonomy as an individualistic concept, in which a rational individual makes decisions about their values and choices without being influenced by others.<sup>334</sup> While liberal theorists do acknowledge that the social context exists, this only goes so far as to say individuals must interact with others.<sup>335</sup> The social context in a liberal view of autonomy can be ignored when a person makes a private and rational decision about what to do.<sup>336</sup>

In relational autonomy, individuality is still an important concept.<sup>337</sup> Despite its liberal foundation, autonomy is still an important concept for relational theorists because it is an important tool to obtain gender equality and it can highlight the dependence that characterizes a person's entire life.<sup>338</sup> Relational autonomy seeks to draw attention to how relationships help or hinder a person's ability to be autonomous, including how membership in social groups affects a person's autonomy.<sup>339</sup> Autonomy can be influenced by both individuals and institutions, and can change over time.<sup>340</sup> Even within the relational nature of humans, individuals are able to have a part in determining who they are going to be; relationships do not entirely determine who we become.<sup>341</sup> Relational autonomy also posits that, in contrast to the liberal conception of autonomy, people are not simply making rational decisions devoid of emotional or other considerations.<sup>342</sup> Downie and Llewellyn argue that emotions are a part of making decisions, and this alone does not make the decision non-autonomous; whether the decision is autonomous will depend on the situation and relationships involved.<sup>343</sup>

The divide between the public and private sphere is not a true divide.<sup>344</sup> All people are influenced by state regulation because the government is increasing what and how much it regulates.<sup>345</sup> However, increased regulation does not prevent an individual from having any

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<sup>333</sup> Susan Sherwin, "Relational Autonomy and Global Threats" in Jocelyn Downie & Jennifer J Llewellyn, eds., *Being Relational: Reflections on Relational Theory and Health Law* (Vancouver, British Columbia: UBC Press, 2012) 13 at 13-14; Llewellyn & Downie, *supra* note 318 at 7; Nedelsky, *supra* note 317 at 85-87, 118-119.

<sup>334</sup> Sherwin, *ibid* at 13-14; Llewellyn & Downie, *ibid* at 7; Nedelsky, *ibid* at 85-87, 118-119.

<sup>335</sup> Nedelsky, *ibid* at 121.

<sup>336</sup> Chris Kaposy & Jocelyn Downie, "Reproductive Choice in Canadian Courts: An Evidence-Based Call for a Move to Relational Autonomy" (2009-2010) 36 *Advoc Q* 86 at 100.

<sup>337</sup> Llewellyn & Downie, *supra* note 318 at 7.

<sup>338</sup> Jocelyn Downie & Jennifer Llewellyn, "Relational Theory & Health Law Policy" (2008) *Special Ed Health L J* 193 at 198; Nedelsky, *supra* note 317 at 42-45.

<sup>339</sup> Nedelsky, *ibid* at 118-119; Sherwin & Winsby, *supra* note 13 at 185.

<sup>340</sup> Nedelsky, *ibid* at 118-119.

<sup>341</sup> Nedelsky, *ibid* at 45-46.

<sup>342</sup> Sherwin & Winsby, *supra* note 18 at 184; Downie & Llewellyn, *supra* note 338 at 203-204.

<sup>343</sup> Downie & Llewellyn, *ibid* at 200-202.

<sup>344</sup> Nedelsky, *supra* note 317 at 127-129; Boyd, *supra* note 325 at 141.

<sup>345</sup> Nedelsky, *ibid* at 130-131; Boyd, *ibid* at 141.

autonomy.<sup>346</sup> One of the goals of relational autonomy is to find a way that state regulation, where it is needed, can be applied in a way which fosters autonomy.<sup>347</sup>

Autonomy can still exist within relationships in which there is a power imbalance.<sup>348</sup> Whether autonomy is enhanced or reduced will depend on the specifics of the relationship.<sup>349</sup> Some relationships necessarily involve power imbalances, such as between a doctor and a patient or a parent and a child, because of the differences in knowledge, power, and authority.<sup>350</sup>

Autonomy may be restricted by a person's circumstances.<sup>351</sup> An individual may not have very many options which are real and desirable choices due to the social, economic, or other socio-cultural circumstances one is in; additionally, one's socially situated position cannot be forgotten when making a decision.<sup>352</sup> A fuller discussion of this matter is below in the section on oppression and relational autonomy.

#### *Relational Autonomy and the Law*

Scholars have applied relational theory to law. Relational theory is helpful in analyzing law because it focuses on how law and rights structure relations, and how this legal structuring impacts an individual's values, such as autonomy.<sup>353</sup> An assumption of relational analysis is that law can be used as a tool to make relations and societal structures more equitable, including helping those who are in the minority or lack power.<sup>354</sup> Relational theory does not always call for more state action to help solve problems, but sometimes seeks different solutions in how government structures relations.<sup>355</sup> There are two methods relational theorists use in analyzing the law.<sup>356</sup> The first method states that one simply needs to focus on relationships to better examine a problem in a way that will account for the relational nature of individuals.<sup>357</sup> The second method involves more substantively examining the content of relationships and arguing

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<sup>346</sup> Nedelsky, *ibid* at 130-131.

<sup>347</sup> Nedelsky, *ibid* at 131-132.

<sup>348</sup> Nedelsky, *ibid* at 153.

<sup>349</sup> Nedelsky, *ibid* at 153.

<sup>350</sup> Nedelsky, *ibid* at 153, 156

<sup>351</sup> Kaposy & Downie, *supra* note 336 at 100; Boyd, *supra* note 325 at 139-141; Sherwin & Winsby, *supra* note 18 at 184.

<sup>352</sup> Sherwin & Winsby, *ibid* at 184.

<sup>353</sup> Nedelsky, *supra* note 317 at 65.

<sup>354</sup> Nedelsky, *ibid* at 68-70.

<sup>355</sup> Nedelsky, *ibid* at 70-71.

<sup>356</sup> Leckey, *supra* note 317 at 13-15.

<sup>357</sup> Leckey, *ibid* at 13-15.

for ones which will lead to increased autonomy.<sup>358</sup>

Relational theory and relational autonomy have been applied to the health law context. For example, Chris Kaposy and Jocelyn Downie used relational autonomy in examining Canadian court cases on reproductive choice.<sup>359</sup> They found that courts concluded women could make autonomous choices when there were actually restrictions on their autonomy imposed by the health care system and their relationships.<sup>360</sup> The authors argued that relational autonomy would be a useful framework for courts to utilize to give a fuller and more accurate picture of what restrictions there are on a woman's choice.<sup>361</sup>

Jocelyn Downie and Jennifer Llewellyn have applied relational autonomy to the area of consent to medical treatment.<sup>362</sup> In the case of negligence in obtaining informed consent, the court considers what a reasonable independent and informed person would have consented to in the patient's position.<sup>363</sup> However, relational theory would argue that emotion and other family members play an important role in decision-making, and this does not make someone's decision unreasonable.<sup>364</sup> They argue that the degree to which the decision was autonomous will depend on what kind of relationship one is in, and whether it increases or decreases one's capacity for autonomy.<sup>365</sup>

Relational autonomy has also been applied to the context of public health ethics.<sup>366</sup> The authors have argued that public health ethics have traditionally used an individualistic view, which is contrary to the reality that the primary focus of public health is on protecting the health of the general public.<sup>367</sup> Relational autonomy can help balance the health needs of the public with concerns for individual autonomy, access to care resources, and the stigma of being ill during a pandemic.<sup>368</sup>

#### *Relational Autonomy, Dependency, and Care Work*

An important assumption of relational theory is that all individuals are dependent on

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<sup>358</sup> Leckey, *ibid* at 13-15.

<sup>359</sup> Kaposy & Downie, *supra* note 336 at 86-88.

<sup>360</sup> Kaposy & Downie, *ibid* at 86-88, 100.

<sup>361</sup> Kaposy & Downie, *ibid* at 86-88, 100.

<sup>362</sup> Downie & Llewellyn, *supra* note 338.

<sup>363</sup> Downie & Llewellyn, *ibid* at 198-199.

<sup>364</sup> Downie & Llewellyn, *ibid* at 200-202.

<sup>365</sup> Downie & Llewellyn, *ibid* at 201-202.

<sup>366</sup> Baylis, Kenny, & Sherwin, *supra* note 317 at 196-198; Kenny, Sherwin, & Baylis, *supra* note 317.

<sup>367</sup> Baylis, Kenny, & Sherwin, *ibid*; Kenny, Sherwin, & Baylis, *ibid*.

<sup>368</sup> Baylis, Kenny, & Sherwin, *ibid*; Kenny, Sherwin, & Baylis, *ibid*.

others.<sup>369</sup> Dependency is particularly salient within the context of elder care. We are dependent at specific times in our lives, such as when are sick, very young, or very old.<sup>370</sup> However, relational theory views people as dependant throughout their lives, not just during these peak times of physical dependence on others.<sup>371</sup>

Relational theory considers dependency to be a core part of the self, and thus considers care to be very important for all people.<sup>372</sup> When there is a segment of the population that is not undertaking care work, such as men due to the gendered division of care work, men are missing an important part of the human experience.<sup>373</sup> Currently, care is not valued in our society and thus neither are those people who are responsible for care work.<sup>374</sup> Policy-makers have created a situation where care work is not equally distributed, and policy-makers do not have the experiences of care and dependency to enable them to make good policy decisions in regards to care work.<sup>375</sup> If care was a central value, women (due to the fact that they provide most of the care work) would be rewarded for this care work, increasing their well-being.<sup>376</sup>

Relational autonomy has been applied to specific situations of dependency and care work. Scholars have applied relational autonomy to examining the situation of elders living in long-term care facilities and assisted living, noting that elders in these care homes experience a significant amount of dependency on the staff, and often face a loss of sense of autonomy due to the threats to their self-concept.<sup>377</sup> In the face of these challenges to autonomy and self-concept, scholars urge that these care facilities focus on ways in which autonomy can be increased as much as possible where these individuals have the ability to express it.<sup>378</sup>

Boyd examined relational autonomy in the context of single mothers providing care for their children.<sup>379</sup> She argued that the current norm of shared parenting is in some cases limiting the autonomy women have regarding choices they can make for themselves and their child.<sup>380</sup> Women who have larger social support networks have more options open to themselves, so for

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<sup>369</sup> Sherwin & Winsby, *supra* note 18 at 186; Nedelsky, *supra* note 317 at 26-27.

<sup>370</sup> Nedelsky, *ibid* at 27.

<sup>371</sup> Nedelsky, *ibid* at 27-28.

<sup>372</sup> Nedelsky, *ibid* at 28; Perkins et al., *supra* note 18 at 17.

<sup>373</sup> Nedelsky, *ibid* at 29.

<sup>374</sup> Sherwin & Winsby, *supra* note 18 at 185-186; Nedelsky, *ibid* at 29.

<sup>375</sup> Nedelsky, *ibid* at 28-29.

<sup>376</sup> Nedelsky, *ibid* at 82-83, 84; Sherwin & Winsby, *supra* note 18 at 185-186.

<sup>377</sup> Perkins et al., *supra* note 18 at 215, 222; Sherwin & Winsby, *ibid* at 183, 189.

<sup>378</sup> Perkins et al., *ibid* at 215; Sherwin & Winsby, *ibid* at 189.

<sup>379</sup> Boyd, *supra* note 325.

<sup>380</sup> Boyd, *ibid* at 138-139.

instance, a woman's inability to move closer to her relationship networks may prevent her from increasing her capacity for autonomy.<sup>381</sup> Boyd argues that societal norms, including gender roles in care work, need to shift in order for women to increase their capacity for autonomy.<sup>382</sup>

### *Relational Autonomy and Oppression*

Relational autonomy has been applied to circumstances of oppression by scholars such as Susan Sherwin and Natalie Stoljar.<sup>383</sup> Oppression can hinder autonomy, including when women are socialized into caregiving roles.<sup>384</sup> Members of an oppressed group have reduced options available to them, including fewer economic opportunities and reduced access to health care or healthy lifestyles.<sup>385</sup> An action can only be autonomous when the action is in line with the individual's interests and values.<sup>386</sup> This includes the interests of the individual's group, such as her gender or race.<sup>387</sup> When a person is oppressed, she is not able to exercise any true autonomy because she does not have any options which meaningfully fit her interests or values.<sup>388</sup> A woman can still express agency in that circumstance, making a choice which is positively reinforced by society, but is against her interests.<sup>389</sup> The authors argue that she cannot fully express autonomy unless the social norms and relationships around her allow her to make a choice which matches her values, and her choice is not negatively reinforced by society.<sup>390</sup>

Oppression can reduce autonomy through indirect methods such as harming one's concept of self.<sup>391</sup> In oppressive circumstances, a person's ability to evaluate his or her self is reduced, and this can cause a lack of trust in one's ability to make decisions.<sup>392</sup> Facing strong gender stereotypes, women may be less likely to try to break with the traditional roles ascribed to them.<sup>393</sup> Individuals may even go so far as to start to incorporate these norms and biases into

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<sup>381</sup> Boyd, *ibid* at 141, 144-146.

<sup>382</sup> Boyd, *ibid* at 150-153.

<sup>383</sup> Sherwin, *supra* note 333 at 17; Natalie Stoljar, "Informed Consent and Relational Conceptions of Autonomy" (2011) 36 *Journal of Medicine and Philosophy* 375.

<sup>384</sup> Sherwin, *ibid* at 17; Boyd, *supra* note 325 at 139-140.

<sup>385</sup> Sherwin & Winsby, *supra* note 18 at 185; Baylis, Kenny, & Sherwin., *supra* note 317 at 202; Kenny, Sherwin, & Baylis, *supra* note 317 at 10; Boyd, *supra* note 325 at 139.

<sup>386</sup> Sherwin, *supra* note 333 at 19; Baylis, Kenny, & Sherwin, *ibid* at 202; Kenny, Sherwin, & Baylis, *ibid* at 10.

<sup>387</sup> Sherwin, *ibid* at 19.

<sup>388</sup> Sherwin, *ibid* at 19; Baylis, Kenny, & Sherwin, *supra* note 317 at 202, Kenny, Sherwin, & Baylis, *supra* note 317 at 10.

<sup>389</sup> Sherwin, *ibid* at 17; Boyd, *supra* note 325 at 145-146.

<sup>390</sup> Sherwin, *ibid* at 17-19; Boyd, *ibid* at 140, 150-152.

<sup>391</sup> Stoljar, *supra* note 383 at 379.

<sup>392</sup> Stoljar, *ibid* at 377-379.

<sup>393</sup> Sherwin & Winsby, *supra* note 18 at 185; Stoljar, *ibid* at 379.

their own beliefs, which may further reduce their capacity for autonomy.<sup>394</sup> Scholars who use relational autonomy seek to examine how oppressive circumstances reduce autonomy, and argue that changes to social norms, social conditions, and government policy are required to enable these individuals to acquire a full capacity to be autonomous.<sup>395</sup>

#### *Relational Autonomy in the Australian Literature*

Relational autonomy has also been utilized in the context of the Australian literature, including in the context of health care.<sup>396</sup> This body of literature also takes the view that individuals are constituted by relationships, and that individuals are also part of a social environment that shapes them.<sup>397</sup> A relational view of autonomy is used by scholars in examining how certain relationships can increase or decrease autonomy.<sup>398</sup> This relational notion of autonomy was utilized by Entwistle et al. in their examination of the clinician-patient context in Australia, arguing that relational concepts of autonomy would help clinicians aid patients in the context of informed consent in a way that would increase the patient's ability to be autonomous in a situation where there is reduced capacity for autonomy.<sup>399</sup> Sherman and Newson examined the regulation of home births in Australia, using relational autonomy to argue that a relational approach would better allow for a compromise between the need for women to make autonomous decisions about their method of birth and the need to protect the mother and baby from harm.<sup>400</sup> The importance of relational theory for examining the concept of dependence in caregiving and situations of oppression is also reflected in the Australian literature.<sup>401</sup> Grahame and Martson examined single mothers on income support who were subject to new welfare-to-work policies, arguing a relational examination illustrates the way in

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<sup>394</sup> Sherwin & Winsby, *ibid* at 185.

<sup>395</sup> Sherwin & Winsby, *ibid* at 184-185; Baylis, Kenny, & Sherwin, *supra* note 317 at 202; Kenny, Sherwin, & Baylis, *supra* note 317 at 10; Boyd, *supra* note 325 at 150-152.

<sup>396</sup> Vikki A Entwistle et al., "Supporting Patient Autonomy: The Importance of Clinician-patient Relationships" (2010) 25:7 J Gen Intern Med 741; Tereza Hendl, "The Complexity of Relational Autonomy: A Holistic Approach to Embodiment" (2016) 16:2 Am J Bioethics 63; Jindalae K Sherman & Ainsley J Newson, "Regulating Risk and the Boundaries of State Conduct: A Relational Perspective on Home Births in Australia" (2016) 16:2 Am J Bioethics 19; Shannon McDermott, "Ethical Decision Making in Situations of Self-neglect and Squalor among Older People" (2011) 5:1 Ethics & Social Welfare 52; Teresa Grahame & Greg Martson, "Welfare-to-work Policies and the Experience of Employed Single Mothers on Income Support in Australia: Where are the Benefits? (2012) 65:1 Aust Social Work 73; S.M. Carter, V.A. Entwistle, & M. Little, "Relational conceptions of paternalism: a way to rebut nanny-state accusations and evaluate public health interventions" (2015) 129 Public Health 1021.

<sup>397</sup> Entwistle et al., *ibid* at 742; Hendl, *ibid* at 64.

<sup>398</sup> Entwistle et al., *ibid* at 742; Sherman & Newson, *supra* note 396 at 20.

<sup>399</sup> Entwistle et al, *ibid* at 742-744.

<sup>400</sup> Sherman & Newson, *supra* note 396 at 19-21.

<sup>401</sup> Grahame & Martson, *supra* note 396 at 76-77.

which oppressed groups can be further stigmatized by these policies and have their capacity for autonomy reduced, arguing for recognizing women as both workers and mothers.<sup>402</sup>

### *Criticisms of Relational Autonomy*

Despite the benefits of relational autonomy in the context of caregiving and health care, there have been some criticisms levelled against this approach. This is not an exhaustive list of arguments against relational autonomy, but this section outlines some of its limitations and responses to this. First, the claim that liberal theories of autonomy ignore the context and impact of relationships may not be the case – several authors note that some branches of liberalism do incorporate the fact that relationships are constitutive into their analysis.<sup>403</sup> Friedman argues that the concept of independence, even in its liberal conception, should not be abandoned by feminist scholars because it can aid oppressed groups seeking to change their circumstances.<sup>404</sup> Friedman also argues that relational autonomy arguments would be stronger if terms were defined clearly, such as what it means to be ‘constituted’ by relationships.<sup>405</sup> Leckey argues in his examination of the relational autonomy literature that the two methods used by relational theorists, weak and strong, are both being used by the same scholars despite claims to be using one method or another, including authors such as Jennifer Nedelsky, who claim one only needs to focus on relationships, but who end up promoting specific types of relationships which increase autonomy.<sup>406</sup> Some scholars in both Canada and Australia have levelled concerns that relational autonomy is not able to be effectively applied to situations of examining and arguing against laws or policies which are ‘paternalistic’, where the state imposes legislation which reduces autonomy in the name of helping a group of people, due to the inconsistent results in analyzing whether autonomy is violated.<sup>407</sup>

### *Application to Research and Analysis*

This thesis uses relational autonomy to analyze the differences in legal treatment of caregivers in Canada and Australia to examine the degree to which each country’s elder care

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<sup>402</sup> Grahame & Martson, *ibid* at 74-77, 83.

<sup>403</sup> Marilyn Friedman, “Relational Autonomy and Individuality” (2013) 63 UTLJ 327 at 329-330, 336-340; Leckey, *supra* note 316 at 9-10.

<sup>404</sup> Friedman, *ibid* at 338-339.

<sup>405</sup> Friedman, *ibid* at 329.

<sup>406</sup> Leckey, *supra* note 317 at 13-17.

<sup>407</sup> Jules Holroyd, “Relational Autonomy and Paternalistic Interventions” (2009) 15 Res Publica 321 at 332, 334-335; John Christman, “Relational Autonomy and the Social Dynamics of Paternalism” (2014) 17 Ethic Theory Moral Prac 369 at 369-370; Carter et al, *supra* note 396 at 1022.



regimes help expand the autonomy of women, and foster the relational nature in which care work exists. Relational autonomy is utilized to suggest policy recommendations for possible elder care reforms in Canada which would allow these care relationships to flourish and allow increased autonomy for both the caregiver and care recipient. Despite the criticisms of relational autonomy, it was chosen because it is an established theory within the area of feminist research, and used in the areas of care work and health law. Importantly, relational autonomy focuses on relationships and this is an important factor because caregiving often takes place between family members. As well, dependency and societal norms are examined in relational theory, which are also important parts of unpaid care work. Despite concerns about application to paternalistic legislation or lack of clear definitions as described above, the need to focus on relationships and social norms is of utmost importance in an area where women may not have a choice in caring for family members.

### Conclusion

This chapter has examined the social science and legal literature on informal care work. In the liberal welfare state, care has become left to family.<sup>408</sup> Within Canada, the BCLI report on informal care work for any family members examined those who are in paid employment, and the legal literature has focused on pension reforms to aid caregivers to have better retirement income.<sup>409</sup> Australia has focused on workplace protections such as flexible work arrangements and discrimination protections.<sup>410</sup> There are varied instrument options available for supporting caregivers.<sup>411</sup> Relational autonomy was described in this chapter and is used to analyze the caregiver supports in the analysis chapter. The next chapter describes the methods used in this thesis.

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<sup>408</sup> Brodie, *supra* note 215; Gill & Bakker, *supra* note 219.

<sup>409</sup> BCLI, *supra* note 3; Kodar, Pension (In)Securities, *supra* note 68; Woodman, *supra* note 268; Yong, *supra* note 268.

<sup>410</sup> Chapman, Anti-Discrimination Law, *supra* note 302; Smith, It's About Time, *supra* note 302; Pocock, Charlesworth, & Chapman, *supra* note 302; Baird, Williamson, & Heron, *supra* note 302.

<sup>411</sup> Howlett, *supra* note 254.

## CHAPTER THREE: METHODOLOGY

This chapter describes the methodology that is used to examine informal elder care work in Canada and Australia. My research question is what are the policy implications of the legal treatment of caregivers of the elderly in Canada and Australia and how can this inform law and policy reforms in Canada.

### Research Materials and General Methodology

The research is limited to examining laws and policies which support informal caregivers who are caring for the elderly outside of formal care facilities, and social and economic data on caregiving. Informal caregivers are defined as family members or close friends of any age, although they are typically female relatives.<sup>412</sup> Care recipients are defined as those who are 65 years of age or older and require care. Caregiving is defined broadly as including managing medical care, assisting the care recipient with basic health care needs at home, aiding in activities of daily living, aiding in instrumental activities of daily living, and providing emotional support.<sup>413</sup> Informal caregiving and care work are both used as terms to describe the unpaid care work that families and friends perform without pay for care recipients. Paid work represents the paid employment that caregivers may engage in. The materials that are researched and analyzed include legislation, policies, and government-authored public information on support for informal caregivers in performing their caregiving activities.

This thesis has both doctrinal and non-doctrinal components. The doctrinal component<sup>414</sup> describes and examines the laws of Canada and Australia as they pertain to the research question. The non-doctrinal component<sup>415</sup> of this research involves analyzing the policy implications of future law reform on informal elder care work within Canada, and examining the social science

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<sup>412</sup> This is a definition which is commonly used in the caregiving literature. Guberman, *supra* note 5 at 75; Armstrong & Kits, *supra* note 6 at 48-53.

<sup>413</sup> This is a definition which is commonly used in the caregiving literature. Armstrong & Kits, *ibid* at 47-48, 62-65; BCLI, *supra* note 3 at 1, 20. ADLs include hygiene and basic medical care. IADLs include food preparation and cleaning (BCLI at 20).

<sup>414</sup> Doctrinal research is that which describes what the law is in a certain area and how it applies, and includes both primary sources of legislation and case law, and secondary sources – Ian Dobson & Francis Johns, “Qualitative Legal Research” in Mike McConville & Wing Hong Chui, eds., *Research Methods for Law* (Edinburgh: Edinburgh University Press, 2007) 16 at 18-19.

<sup>415</sup> Non-doctrinal research is all other legal research, including policy and law reform research, which commonly examines social factors involved in a legal problem. This non-doctrinal research is important for this comparative project because the majority of Australian legal analysis is non-doctrinal research. Dobson & Johns, *ibid* at 18-20.

research on the impacts of informal care work on the caregivers themselves and the gender roles in each country for care work.

The primary methodology is comparative research on the laws affecting informal care work in Canada and Australia, and analyzing the two countries' laws through the theoretical lens of relational autonomy. A comparative legal examination can help elucidate a legal question or societal problem in one's own country, even though the method looks outward.<sup>416</sup> The benefit of looking at external legal systems comes from seeing possible laws that could aid in national problems, or seeing where laws have not adequately dealt with a social issue.<sup>417</sup> Some social problems are present in all societies, so there is a benefit in seeing how each country deals with this problem, be it in distinct or similar manners.<sup>418</sup> Aging and care needs in old age are problems which countries all over the world are dealing with, making comparative studies of aging and state responses useful in examining the legal solutions employed by each country.<sup>419</sup> Comparative research on aging has also begun to use a feminist perspective, especially when the research touches on aspects of caregiving labour.<sup>420</sup> My research uses the feminist lens of relational autonomy.

The two countries that are compared are Canada and Australia. Comparative research on aging has commonly compared and contrasted countries which are similar to each other, such as countries that are both welfare states, or both located in the global north.<sup>421</sup> Countries which have similar histories often have similar institutional structures, cultures, and socio-economic environments, and may converge even more in these areas over time, which make these countries easier to compare and contrast.<sup>422</sup> Countries in the global south and Asia do have a significant percentage of the world's elderly and these countries are not frequently examined in comparative research studies.<sup>423</sup> However, even though there is a gap in the aging literature examining these countries, there are reasons to study a country with a similar background to Canada, because the focus of this thesis is on the legal framework for caregivers of the elderly. Examining a country

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<sup>416</sup> Geoffrey Wilson, "Comparative Legal Scholarship" in Mike McConville & Wing Hong Chui, eds., *Research Methods for Law* (Edinburgh: Edinburgh University Press, 2007) 87 at 87-88.

<sup>417</sup> Wilson, *ibid* at 87-88.

<sup>418</sup> Wilson, *ibid* at 92.

<sup>419</sup> Sheila M Neysmith & Jane Aronson, "Global Aging and Comparative Research: Pushing Theoretical and Methodological Boundaries" (2012) 26 *J Aging Studies* 227 at 227-228.

<sup>420</sup> Neysmith & Aronson, *ibid* at 228-229.

<sup>421</sup> Neysmith & Aronson, *ibid* at 227.

<sup>422</sup> Neysmith & Aronson, *ibid* at 227-228.

<sup>423</sup> Neysmith & Aronson, *ibid* at 227-229.

with the same type of legal system as one's own – in this case common law – may help in the comparative analysis because the countries may apply a similar approach and structure to the law, as well as similar socio-economic circumstances.<sup>424</sup> Law reform analyses within one common law jurisdiction often compare their own laws with another common law country.<sup>425</sup> Australia, being a Commonwealth common law jurisdiction like Canada, has enough legal system and socio-economic similarities to enable a comparison of their laws, and be more applicable to an analysis of future law reform efforts in Canada than comparing a country with a completely different legal system and socio-economic situation.

Within Canada, I focus on the laws and policies in BC and Ontario, while noting relevant laws and policies that exist federally and a few other noteworthy ones in provinces. Ontario is examined because, as the most populous province in Canada, it has the largest number of seniors,<sup>426</sup> which means there will be a significant amount of care work needed from family and friends. BC is chosen because it has a large number of seniors, having the third largest number of seniors in Canada.<sup>427</sup> BC has a significant proportion of seniors at 18.3%, of the population, with some communities in BC having a significantly higher proportion of seniors – the highest is Qualicum Beach where 52.1% are seniors.<sup>428</sup>

This research includes examining the socio-economic situation of caregivers of the elderly in both countries, and the gender roles that that are the context for caregiving activities, which will be discussed in the next section. Examining the context within which the laws on caregivers exist allows for a fuller understanding of whether the laws actually do help the caregivers and care recipients that they are aimed to assist.<sup>429</sup> The socio-economic context of each country impacts the legal system, just as the laws put into place impact those who are subject to the laws.<sup>430</sup> The non-legal context is also important because laws alone may not be

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<sup>424</sup> Wilson, *supra* note 452 at 87-88, 95-96; Dobinson & Johns, *supra* note 414 at 20.

<sup>425</sup> Wilson, *ibid* at 88.

<sup>426</sup> Canada, Statistics Canada, "Population by sex and age group, by province and territory", online: <[www.statcan.gc.ca/tables-tableaux/sum-som/l01/cst01/demo31a-eng.htm](http://www.statcan.gc.ca/tables-tableaux/sum-som/l01/cst01/demo31a-eng.htm)>.

<sup>427</sup> *Ibid*.

<sup>428</sup> Tavia Grant & Jeremy Agius, "Census 2016: The growing age gap, gender ratios and other key takeaways", *The Globe and Mail* (3 May 2017) online: <[www.theglobeandmail.com](http://www.theglobeandmail.com)>; Éric Grenier, "Canadian seniors now outnumber children for 1st time, 2016 census shows", *CBC* (3 May 2017) online: <[www.cbc.ca](http://www.cbc.ca)>.

<sup>429</sup> Wilson, *supra* note 416 at 91-92; Dobinson & Johns, *supra* note 414 at 20.

<sup>430</sup> Wilson, *ibid* at 92-93; Dobinson & Johns, *ibid* at 20.

enough to solve a societal problem such as care of the aging; a combination of legal and community solutions may be needed to adequately address the social and economic problems.<sup>431</sup>

### **Detailed Research Methods and Source Locations**

The introduction examines the social constructions of gender roles, the demographics of care work, and the physical, emotional, and economic impacts on caregivers. This is primarily accomplished by searching secondary literature from a variety of related disciplines. I locate sociology, psychology, social work, and legal periodicals and books on how gender roles impact the division of caregiving labour in the family through keyword searches on periodical databases such as PsychInfo and Scholars Portal. Research on the negative and positive impacts on informal caregivers is investigated through periodicals, books, and government statistical and census research found using keyword searches on periodical databases, and investigating StatsCanada websites and equivalent work in Australia. Demographic research is examined on who does what type of care work in each country, through social science research and government statistical research on the subject of caregiving. I look at the research covering the past 10 years to limit the search to recent caregiving trends and impacts.

The research chapters first examine the current community care supports in place to aid informal caregivers of the elderly in Canada and Australia. This includes how and what care is provided through government and health care institutions, private for-profit sources of care, non-profit community providers of care, and unpaid care work by family and friends. I locate this information from several sources, including websites and secondary academic sources. Government, health care, and community websites outlining care options for seniors are identified using internet search engine keyword searches. Secondary academic sources, including articles and books, on community care for seniors are located using keyword searches in periodical and text databases such as Heinonline, Legaltrac, AGIS, ScholarsPortal, and library collections databases.

The research chapters next describe in detail the current laws which are aimed at supporting informal caregivers of the elderly in Australia and Canada. To find this information, I examine legislation, case law, and policy documents. I locate legislation and regulations through reading legal encyclopaedias, relevant statutes (available on government websites) and using search engines such as Austlii, Canlii, Westlaw, and LexisNexis, and secondary sources such as

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<sup>431</sup> Wilson, *ibid* at 92.

textbooks and periodicals describing what laws are in place. Once relevant legislation is located, I retrieve policy documents relevant to informal caregivers. Database searches use the terms “elder care”, “elder caregiver”, and “elder law” for Canadian materials, and “aged care” and “aged caregiver” for Australian materials.

The analysis chapter analyzes the degree to which the two countries have similar supports for informal caregivers of the elderly, or the extent to which one country has greater legal and community supports for the caregiver. This chapter also critically examines the supports for caregivers in each country, including the legal and other literature analyzing these supports and their impact on caregivers.

The analysis chapter next explains and critically examines through the lens of relational autonomy the degree to which each country’s supports allow the autonomy of caregivers and care recipients to flourish within the context of the relationships in which they are embedded. Additionally, the analysis looks at the degree to which caregivers, within their relationships with care recipients, have a real choice whether to engage in caregiving activities, or a choice in what types of care they provide.

The analysis chapter then discusses the policy implications of Canada and Australia’s care supports to assess how they could guide possible elder care reforms within Canada. These policy implications are grounded in the goal of having future elder care supports recognize the relational nature of care work. Recognizing the relational nature of care work, and how this influences autonomy, would help to shape future reforms that would give women a choice in whether to perform care work, and help reduce the degree to which caregiving activities can harm women physically, emotionally, and economically.

## **CHAPTER FOUR: CANADA’S HOME CARE SYSTEM AND SUPPORTS FOR INFORMAL CAREGIVERS**

This chapter examines the legislation and policy for home and community care and caregiver supports in Canada. First, this chapter examines BC and Ontario’s home and community care programs, including what formal care elderly Canadians have access to, to give examples of formal elder care in two large provinces across the country. This includes both public information available on websites, and a brief examination of the legislation and policy under which the home and community care programs are run. Second, this chapter examines what government supports are available to informal caregivers of the elderly in Canada, including federal and provincial legislation.

### **Provincial Home and Community Care Programs**

In Canada, health care is a publicly funded health system where the responsibilities primarily lie with the provincial governments.<sup>432</sup> The federal government does set general standards for the public health care system across Canada, such as that it is publicly run not for profit and that it is universal, and also contributes some funds for health care to each province.<sup>433</sup> The provinces run their own health insurance programs for their residents, set their own policies, and manage and deliver the health care.<sup>434</sup> In BC, care is delivered locally at the level of 6 Health Authorities, and in Ontario in 14 Local Health Integration Networks.<sup>435</sup>

### **British Columbia Home and Community Care**

The BC home and community care program provides subsidized care for clients (care recipients) who need health care, support services, or both, discussed in detail below.<sup>436</sup> The stated goal of this health care program is to allow individuals to remain in their homes or

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<sup>432</sup> Canada, “Canada’s Health Care System”, online: <[www.canada.ca/en/health-canada/services/canada-health-care-system.html](http://www.canada.ca/en/health-canada/services/canada-health-care-system.html)>.

<sup>433</sup> *Ibid.*

<sup>434</sup> *Ibid.*; British Columbia, “Health Care Programs and Services”, online: <[www2.gov.bc.ca/gov/content/family-social-supports/seniors/health-safety/health-care-programs-and-services](http://www2.gov.bc.ca/gov/content/family-social-supports/seniors/health-safety/health-care-programs-and-services)>; Ontario, “Understanding Health Care in Ontario”, online: <[www.health.gov.on.ca/en/ministry/hc\\_system/#](http://www.health.gov.on.ca/en/ministry/hc_system/#)>.

<sup>435</sup> *Ibid.*; Ontario, “Ontario’s LHINs”, online: <[www.lhins.on.ca/](http://www.lhins.on.ca/)>.

<sup>436</sup> Province of British Columbia, “Home and Community Care”, online: <[www2.gov.bc.ca/gov/content/health/accessing-health-care/home-community-care](http://www2.gov.bc.ca/gov/content/health/accessing-health-care/home-community-care)> [BC H&CC Website]. Rates of care and eligibility criteria will be discussed in more detail below.



communities as long as possible.<sup>437</sup> There are several types of supports that the health care system provides: home care, which includes nursing, rehabilitation, adult day services, home support by health workers, and caregiver respite or relief; assisted living; and residential care services.<sup>438</sup> For clients to start receiving care, they either need to contact the health authority themselves, or be referred by a health professional.<sup>439</sup> Case managers will then determine if the client is eligible, determine the client rate (explained below), and develop a care plan.<sup>440</sup> The general eligibility criteria for home and community care include being at least 19 years of age, being a Canadian citizen or permanent resident, living in BC, and needing support to be able to remain in one's own home due to a medical condition or chronic illness.<sup>441</sup>

The manner in which formal home care is provided and the policies which underlie it illustrate the significant extent to which the formal system relies on informal caregiving. The government-subsidized care is "...designed to complement and supplement, but not replace, your efforts to care for yourself with the assistance of your family, friends and community."<sup>442</sup> The home and community care policy manual states that home and community care should be "sustainable, demonstrating effective use of health resources to achieve positive outcomes for clients, caregivers..."<sup>443</sup> These statements stress a state expectation of and the continued importance of informal care provided by friends and family, placing the responsibility on the family not the public sector.

Care is prioritized on a basis of urgency. Because there may not be enough health care resources to meet the needs of all individuals in the province needing care, those most in need receive care first and the clients determined less in need of formal care are placed on the waitlist in order of urgency.<sup>444</sup> The urgency criteria include health status, potential risks of the client living in their current situation, and whether the client has friends or family providing care.<sup>445</sup> Having family or friends caring can prevent a client from receiving home care as soon as others of a similar medical status if those other individuals do not have an informal caregiver.

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<sup>437</sup> BC H&CC Website, *ibid*.

<sup>438</sup> BC H&CC Website, *ibid*.

<sup>439</sup> BC H&CC Website, *ibid*; Best of Care, *supra* note 16 at 37-38.

<sup>440</sup> BC H&CC Website, *ibid*; Best of Care, *ibid* at 37-38.

<sup>441</sup> BC H&CC Website, *ibid*; BC H&CC Policy Manual, *supra* note 16 at s 2.B 1 of 5 to 4 of 5.

<sup>442</sup> BC H&CC Website, *ibid*.

<sup>443</sup> BC H&CC Policy Manual, *supra* note 16 at 1.A 2 of 4.

<sup>444</sup> BC H&CC Website, *supra* note 436; BC H&CC Policy Manual, *ibid* at 2.C 1 of 1.

<sup>445</sup> BC H&CC Website, *ibid*; Best of Care, *supra* note 16 at 16; BC H&CC Policy Manual, *ibid* at s 2C pg 1 of 1. See the below section on use of the formal care system for a discussion of unmet need for home care.

In BC, home and community care is subsidized by the government, but is also accompanied by a fee the client must pay.<sup>446</sup> The amount the care recipient must pay is called the client rate.<sup>447</sup> Some services charge different client rates, but for most of the services the client rate is based on the recipient's income.<sup>448</sup> There is no maximum client rate if the client has not earned any income; however, if a client has earned income the maximum is \$300 per month.<sup>449</sup> The ombudsperson notes that the fact that the cap only applies to those with earned income is problematic because "[t]his means that seniors who have a relatively large income that includes some earned income may end up paying lower home support fees than seniors with less overall income but no earned income."<sup>450</sup> If the client is receiving an income benefit such as Old Age Security (OAS) they are not charged a client rate.<sup>451</sup>

BC's home and community care is governed by a few statutes and their regulations. The *Continuing Care Act (CCA)*<sup>452</sup> allows for health care provided in the home by the government outside of hospitals, and its regulations set out the client fees for home and community care services.<sup>453</sup> The *Community Care and Assisted Living Act*<sup>454</sup> (CCALA) sets out the standards for community care facilities, assisted living residences, and residential care facilities.<sup>455</sup> The BC Ministry of Health Home and Community Care Policy Manual sets out in detail the administration of home and community care, including eligibility for services, the processes of how to receive these care services, and the client rates.<sup>456</sup>

Formal in-home care is provided by the health care system to help seniors remain in their home and community as long as possible.<sup>457</sup> Home care services include nursing care, rehabilitation services, adult day programs, and home support services.<sup>458</sup> Home support is provided by health care workers to assist clients with personal hygiene activities, moving around

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<sup>446</sup> BC H&CC Website, *supra* note 436.

<sup>447</sup> BC H&CC Website, *ibid*.

<sup>448</sup> BC H&CC Website, *ibid*; BC H&CC Policy Manual, *supra* note 16 at 7.B.1 1 of 3 to 3 of 3; *Continuing Care Fees Regulation*, BC Reg 330/97, s 3(1).

<sup>449</sup> Best of Care, *supra* note 16 at 38-39; BC Reg 330/97, s 3(1.1).

<sup>450</sup> Best of Care, *ibid* at 39.

<sup>451</sup> BC H&CC Policy Manual, *supra* note 16 at 7.B.2 1 of 3; BC Reg 330/97, s 3(2).

<sup>452</sup> *Continuing Care Act*, RSBC 1996, c 70 [CCA].

<sup>453</sup> CCA, *ibid*, s 3; *Continuing Care Programs Regulation* BC Reg 146/95; BC Reg 330/97.

<sup>454</sup> CCALA, *supra* note 18.

<sup>455</sup> CCALA, *ibid*; *Residential Care Regulation*, BC Reg 96/2009. The requirements for facilities are described in greater detail below.

<sup>456</sup> BC H&CC Policy Manual, *supra* note 16.

<sup>457</sup> Best of Care, *supra* note 16 at 32.

<sup>458</sup> BC H&CC Policy Manual, *supra* note 16 at 4.A 1 of 3.

the home, and some nursing or rehabilitation activities. The general eligibility criteria are that clients need assistance to stay in their home, the client does not have adequate care through their family and friends, staff can safely provide care, and that there are adequate public resources to provide this care.<sup>459</sup> If there are not enough home care services available, home support must be prioritized to the clients who have the greatest health concerns and would be at the greatest risk if they do not receive this care; clients who are of lower priority are placed on a waitlist.<sup>460</sup>

Nursing care may be provided within the home by licenced nurses who perform care such as caring for wounds and chronic illnesses and education on health issues.<sup>461</sup> Licenced physical therapists or occupational therapists may also assist with assessments and treatments.<sup>462</sup> Both nursing and rehabilitation services are usually received for only a short period of time, typically after discharge from the hospital.<sup>463</sup> After this, family or friends must take over the nursing or rehabilitation tasks if they are still needed.<sup>464</sup> If friends or family are deemed able to provide this care but are not willing to do so, nursing or rehabilitation services can be stopped.<sup>465</sup> This requirement demonstrates that family is expected to provide care first. There is no client rate for either nursing or rehabilitation services, except for the cost of any supplies used.<sup>466</sup>

Adult Day Programs are sessions outside of the home where the care recipient takes part in recreation and social activities, therapy, and personal care.<sup>467</sup> Adult Day Services may (but are not required to) provide services for caregivers such as respite care, education, and support groups.<sup>468</sup> Clients who meet the general eligibility for home and community care are eligible for the day programs, and there is a client rate for day programs, to a maximum of \$10 per day.<sup>469</sup>

Home support does not usually include helping clients with tasks such as providing emotional or social support, home maintenance, cleaning, and transportation.<sup>470</sup> However the government has created a pilot program called Better at Home, which is administered through

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<sup>459</sup> BC H&CC Policy Manual, *ibid* at 4.B.1 1 of 1, 4.B.2 1 of 1.

<sup>460</sup> BC H&CC Policy Manual, *ibid* at 4.B.1 1 of 1, 4.B.2 1 of 1; 2.C 1 of 1; BC H&CC Website, *supra* note 436.

<sup>461</sup> BC H&CC Website, *ibid*.

<sup>462</sup> BC H&CC Website, *ibid*.

<sup>463</sup> BC H&CC Website, *ibid*; BC H&CC Policy Manual, *supra* note 16 at 4.D 1 2 of 2, 4.E 1 of 2.

<sup>464</sup> BC H&CC Website, *ibid*.

<sup>465</sup> BC H&CC Policy Manual, *supra* note 16 at 4.D 2 of 2, 4.E 1 of 2.

<sup>466</sup> BC H&CC Policy Manual, *ibid* at 4.D 2 of 2, 4.E 1 of 2.

<sup>467</sup> BC H&CC Website, *supra* note 436.

<sup>468</sup> BC H&CC Policy Manual, *supra* note 16 at 4.F 1 of 1.

<sup>469</sup> BC H&CC Policy Manual, *ibid* at 4.F 1 of 1, 7.C.2 1 of 1.

<sup>470</sup> Best of Care, *supra* note 16 at 32.

the United Way of the Lower Mainland to provide these home services.<sup>471</sup> To be eligible, clients must live in one of the 68 communities which have a program office, and be assessed as needing the services.<sup>472</sup> There is a client rate for the service, although most clients received a full or partial subsidy.<sup>473</sup>

Assisted Living refers to residences for seniors who require some assistance with daily tasks and some care, but are still able to make decisions about their own care and daily life.<sup>474</sup> For those seniors who can no longer live in their own home or in assisted living, residential care is available.<sup>475</sup> Residential care includes nursing services, meals, daily care, and recreation.<sup>476</sup> Eligibility criteria for residential care includes whether the client has a caregiver who is able to assist them within their current residence.<sup>477</sup>

### Ontario Home and Community Care

In Ontario, the government provides home and community care services because “[s]eniors, and people with complex medical conditions, can often stay in their own homes if they have some support.”<sup>478</sup> The government provides a range of services which include nursing and rehabilitation, personal care services, housekeeping, respite care, and long-term care homes.<sup>479</sup> Home support services are provided with no fees for eligible clients.<sup>480</sup> To receive care, a case manager will assess whether individuals are eligible for services, determine what the client’s needs are, and conduct a home visit.<sup>481</sup> If the client does not qualify for government-funded care, the case managers provide referrals for private paid care.<sup>482</sup> Access to all services is

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<sup>471</sup> Province of British Columbia, “Better at Home” <[www2.gov.bc.ca/gov/content/family-social-supports/seniors/health-safety/health-care-programs-and-services/better-at-home](http://www2.gov.bc.ca/gov/content/family-social-supports/seniors/health-safety/health-care-programs-and-services/better-at-home)>; Better at Home, “Frequently Asked Questions” <[www.betterathome.ca/](http://www.betterathome.ca/)> [Better at Home Website].

<sup>472</sup> BC H&CC Website, *supra* note 436; Better at Home Website, *ibid*.

<sup>473</sup> Better at Home Website, *ibid*; United Way, *United Way’s Better at Home A Year in Review April 1, 2014 – March 31, 2015*, online: <[hwww.betterathome.ca/](http://www.betterathome.ca/)> [A Year in Review] at 5.

<sup>474</sup> Best of Care, *supra* note 16 at 47-48; BC H&CC Policy Manual, *supra* note 16 at 5.B 1 of 2. A full examination of assisted living and residential care is beyond the scope of this thesis.

<sup>475</sup> Best of Care, *supra* note 16 at 69.

<sup>476</sup> Best of Care, *ibid* at 69.

<sup>477</sup> Best of Care, *ibid* at 76; BC H&CC Policy Manual, *supra* note 16 at 6.C 1 of 2.

<sup>478</sup> Ont H&CC Website, *supra* note 20.

<sup>479</sup> Ont H&CC Website, *ibid*; Ontario, Ministry of Health and Long-Term Care, *Community Care Access Centres: Client Services Policy Manual*, January 2007 update [CCAC Policy Manual] at ch 1.

<sup>480</sup> Ontario Ministry of Health and Long-Term Care, “Community Care Access Centres” <[www.health.gov.on.ca/en/common/system/services/ccac/](http://www.health.gov.on.ca/en/common/system/services/ccac/)> [MOHLTC CCAC Website].

<sup>481</sup> Ont H&CC Website, *supra* note 20; MOHLTC CCAC Website, *ibid*; CCAC Policy Manual, *supra* note 479 ch 1 at 15-17.

<sup>482</sup> MOHLTC CCAC Website, *ibid*.

coordinated through the Local Health Integrated Networks (LHINs).<sup>483</sup>

Home and community care in Ontario is governed by several pieces of legislation and policy. The *Home Care and Community Services Act, 1994*<sup>484</sup> (*HCCSA*) sets out information on home care such as funding, rules for agencies designated to provide home care services, complaint and appeal processes for clients, and definitions.<sup>485</sup> Under the *HCCSA*, the Provision of Community Services regulation<sup>486</sup> sets out details of the specific home care services, such as eligibility and the maximum number of hours allowed for homemaking services, personal support services, and professional services.<sup>487</sup> The *Long-Term Care Homes Act, 2007*<sup>488</sup> and its regulations set out the regulations for long-term care homes, including short-stay respite care.<sup>489</sup>

There are a myriad of support services which an eligible client can receive in their home, including professional health care services, personal care, and homemaking.<sup>490</sup> Professional services include nursing care, rehabilitation services, nutrition, and social work.<sup>491</sup> Nursing includes help with medication, wound care, and health plans.<sup>492</sup> Social work services are provided not just to the care recipient, but also to their informal caregivers and other family members.<sup>493</sup> The eligibility criteria for professional services are that the care recipient has Ontario health insurance, the care provider can safely provide services,<sup>494</sup> “[t]he services must be necessary to enable the person to remain in his or her home or enable him or her to return home from a hospital or other health care facility”<sup>495</sup> and “...the services must be reasonably expected to result in progress towards, i. rehabilitation, [or] ii. maintenance of functional status....”<sup>496</sup>

Personal support services include aiding care recipients with personal hygiene tasks,

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<sup>483</sup> Ont H&CC Website, *supra* note 20; Ontario, CCAC Policy Manual, *supra* note 479 at 15. Home care services were transferred from the CCACs to the LHINs in May and June 2017 (Ontario, Ministry of Health and Long-Term Care, “Health Bulletins, The Patients First Act”, online:

<[www.health.gov.on.ca/en/news/bulletin/2016/hb\\_20161207\\_faq.aspx](http://www.health.gov.on.ca/en/news/bulletin/2016/hb_20161207_faq.aspx)> Dec 7, 2016; Kate Porter, “Ontario set to being shifting home care responsibilities”, *CBC* (25 April 2017) online: <[www.cbc.ca](http://www.cbc.ca)>.)

<sup>484</sup> *Home Care and Community Services Act, 1994*, SO 1994, c 26 [*HCCSA*], s 2(5). (The *HCCSA* was previously titled the Long-Term Care Act).

<sup>485</sup> *HCCSA*, *ibid*; MOHLTC CCAC Website, *supra* note 480.

<sup>486</sup> *Provision of Community Services*, O Reg 386/99.

<sup>487</sup> O Reg 386/99; MOHLTC CCAC Website, *supra* note 480.

<sup>488</sup> *Long-Term Care Homes Act, 2007*, SO 2007, c 8 [*LTCHA*].

<sup>489</sup> *LTCHA*; O Reg 79/10, s 155, 156.

<sup>490</sup> Ont H&CC Website, *supra* note 20.

<sup>491</sup> *Ibid*; *HCCSA*, *supra* note 484, s 2(7); O Reg 386/99, s 3.1.

<sup>492</sup> Ont H&CC Website, *supra* note 20.

<sup>493</sup> Ont H&CC Website, *ibid*.

<sup>494</sup> O Reg 386/99, s 3.4.

<sup>495</sup> O Reg 386/99, s 3.4.

<sup>496</sup> O Reg 386/99, s 3.4.

moving around their residences, and transportation.<sup>497</sup> The eligibility criteria for personal support services are that the care recipient has Ontario health insurance, and the staff would safely be able to provide these services within the home.<sup>498</sup>

Homemaking services are provided in Ontario directly through the home care program, and include cleaning the home, taking the care recipient to conduct errands, and helping with meals.<sup>499</sup> The eligibility criteria for homemaking services are that the care recipient has Ontario health insurance, the client or their caregiver needs assistance with homemaking, and it would be safe for staff to provide these services in the home.<sup>500</sup> The policy manual states that any cleaning should only be minimal cleaning unless the care recipient would be at risk.<sup>501</sup>

Long-term care homes are available for eligible care recipients who need continuous assistance with daily tasks and nursing, and have provincial health care coverage.<sup>502</sup> If the client does not qualify for government-provided home care services, or only some services, each home care office must keep information about what services are available in their community.<sup>503</sup> The database must include health, social, and other community services, and information on what government funding is available.<sup>504</sup>

### **Use of the Formal Health Care System**

Seniors represented the greatest proportion of users of home and community care services.<sup>505</sup> In BC in the year 2009/2010, 24,724 seniors used these services, which is under 4% of the seniors in BC.<sup>506</sup> For that same year, the government spent \$339 million on home support.<sup>507</sup> The BC Ombudsperson however found that the majority of older seniors had never been assessed to determine if they were eligible for home support services.<sup>508</sup> For the client fee, 71% of care recipients received a full subsidy.<sup>509</sup> The Better at Home program was used by 6,058

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<sup>497</sup> Ont H&CC Website, *supra* note 20; HCCSA, *supra* note 484, s 2(6).

<sup>498</sup> O Reg 386/99, s 2.1.

<sup>499</sup> Ont H&CC Website, *supra* note 20; HCCSA, *supra* note 484 s 2(5).

<sup>500</sup> O Reg 386/99 s 2.

<sup>501</sup> CCAC Policy Manual, *supra* note 479, ch 7 at 10.

<sup>502</sup> Seniors' Secretariat Guide, *supra* note 21; CCAC Policy Manual, *ibid*, ch 1 at 7; O Reg 79/10 s 155. A full examination of long-term care homes is beyond the scope of this thesis.

<sup>503</sup> MOHLTC CCAC Website, *supra* note 480.

<sup>504</sup> CCAC Policy Manual, *supra* note 479, ch 5 at 1-3.

<sup>505</sup> Best of Care, *supra* note 16 at 12.

<sup>506</sup> Best of Care, *ibid* at 32.

<sup>507</sup> Best of Care, *ibid* at 32.

<sup>508</sup> Best of Care, *ibid* at 17.

<sup>509</sup> Best of Care, *ibid* at 32.



seniors in 2014/2015.<sup>510</sup> Half of the program recipients received a partial subsidy and 35% received a full subsidy.<sup>511</sup> The amount of home care available in Canada, including BC and Ontario may go up in the coming years. The federal government will be giving “an additional \$11 billion over 10 years to better support home care and mental health initiatives.”<sup>512</sup>

In Ontario, approximately 1.46 million individuals receive home and community services.<sup>513</sup> Since 2003, home and community care service usage has doubled.<sup>514</sup> However, use of long-term care homes has decreased.<sup>515</sup> The Expert Group on Home and Community Care found that respite care services were provided infrequently.<sup>516</sup> In 2013/2014, the Ontario government spent \$3.2 million on all home and community services.<sup>517</sup> In 2015, the province added \$270 million into home and community care services to increase personal support, homemaking, and nursing services.<sup>518</sup>

Canadian surveys have attempted to determine how much unmet need there is for home care, either formal or informal. Data from the Canadian Community Health Survey found that 4% of seniors reported having some unmet need for home care, with this number being higher for women than men.<sup>519</sup> Some factors increase the likelihood of having unmet needs for home care – the GSS found that for adult care recipients, having lower income and being a caregiver themselves made it more likely to have unmet or partially unmet needs.<sup>520</sup> Of people who had help but were not happy with the amount of formal versus informal care, the majority of these people would rather have more formal care than they were receiving.<sup>521</sup>

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<sup>510</sup> A Year in Review, *supra* note 473 at 3.

<sup>511</sup> A Year in Review, *ibid* at 5.

<sup>512</sup> 2017 Budget, *supra* note 222 at 155-157. The budget notes in its gender statement that women provide more of the caregiving, and this increased funding could be used to support unpaid caregivers through increased respite care (at 235).

<sup>513</sup> Province of Ontario, Ministry of Health and Long-Term Care, *Patients First A Roadmap to Strengthen Home and Community Care* (2015) <[www.health.gov.on.ca/en/ms/ecfa/healthy\\_change/](http://www.health.gov.on.ca/en/ms/ecfa/healthy_change/)> [Patients First] at 5.

<sup>514</sup> Expert Group on Home and Community Care, *Bringing Care Home* (March 2015) <[www.health.gov.on.ca/en/public/programs/ccac/](http://www.health.gov.on.ca/en/public/programs/ccac/)>[Bringing Care Home] at 1.

<sup>515</sup> *Bringing Care Home*, *ibid* at 7.

<sup>516</sup> *Bringing Care Home*, *ibid* at 20.

<sup>517</sup> *Bringing Care Home*, *ibid* at 6.

<sup>518</sup> Province of Ontario, Newsroom, “Ontario Launches Home Care Plan to Improve Access and Expand Services” (May 13, 2015) <[news.ontario.ca/mohltc/en/2015/05/ontario-launches-home-care-plan-to-improve-access-and-expand-service.html](http://news.ontario.ca/mohltc/en/2015/05/ontario-launches-home-care-plan-to-improve-access-and-expand-service.html)>.

<sup>519</sup> Canada, Statistics Canada, *Seniors’ Use of and Unmet Needs for Home Care, 2009*. By Melanie Hoover & Michelle Rotermann, Catalogue no 82-003-X Health Reports (Ottawa: Statistics Canada, December 2012) at 6.

<sup>520</sup> Turcotte, Unmet Needs, *supra* note 26 at 4-5.

<sup>521</sup> Canada, Statistics Canada, *Receiving Care at Home*. By Marie Sinha & Amanda Bleakney, Catalogue No 89-652-X No 002 (Ottawa: Statistics Canada, June 2014) at 13.



These studies, when asking about unmet needs for home care, counted both informal and formal sources,<sup>522</sup> so it is difficult to disentangle exactly how much unmet need there is for formal care as the informal care could be picking up the slack. Turcotte also notes that it is hard to measure unmet need for home care in seniors, and those living in assisted living or long-term care are excluded in these studies.<sup>523</sup> The Canadian Institute for Health Information studied how seniors moved through the formal care system, and found that 22% of seniors entered residential care before they may have needed to, and one factor in this is not having an informal caregiver.<sup>524</sup> Many seniors also waited in hospital when they no longer required hospital care because they were waiting for home care to become available, for an average of 34 days across Canada.<sup>525</sup> This was longer than the time waiting in hospital for residential care to become available.<sup>526</sup> The lack of home care services can put pressure on both informal caregivers as well as the rest of the formal health care system.

### **British Columbia Caregiver Supports**

#### *Government-Provided Caregiver Information and Education*

Several levels of the health care system do have some brief information on their public websites for caregivers. The Province of BC's seniors section of its website has a subsection for informal caregivers of the elderly.<sup>527</sup> The HealthLinkBC Website also provides tips for caregivers: for caregivers to take time away from caring, to try to enable the care recipient to retain as much independence as possible, and to ask others for help.<sup>528</sup> Health authorities also provide some information. Fraser Health Authority has a thorough printed handbook for caregivers.<sup>529</sup> The handbook includes information about what changes care receivers experience, impacts on caregivers, how to manage caregiving burdens, and tips on how to provide care to

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<sup>522</sup> Hoover & Rotermann, *supra* note 519; Turcotte, Unmet Needs, *supra* note 26; Sinha & Bleakney, *ibid*.

<sup>523</sup> Turcotte, Unmet Needs, *ibid* at 2-3.

<sup>524</sup> Canadian Institute for Health Information, *Seniors in Transition Exploring Pathways Across the Care Continuum* Ottawa: Canadian Institute for Health Information, 2017), online: <[www.cihi.ca/sites/default/files/document/seniors-in-transition-report-2017-en.pdf](http://www.cihi.ca/sites/default/files/document/seniors-in-transition-report-2017-en.pdf)> [CIHI, Seniors in Transition] at 17-20.

<sup>525</sup> CIHI, Seniors in Transition, *ibid* at 25-26.

<sup>526</sup> CIHI, Seniors in Transition, *ibid* at 25-26.

<sup>527</sup> Province of BC, "Caring for Seniors" online: <[www2.gov.bc.ca/gov/content/family-social-supports/seniors/caring-for-seniors](http://www2.gov.bc.ca/gov/content/family-social-supports/seniors/caring-for-seniors)> [Caring for Seniors Website].

<sup>528</sup> HealthLinkBC, "Caregiver Tips" online: <[www.healthlinkbc.ca/healthtopics/content.asp?hwid=cares](http://www.healthlinkbc.ca/healthtopics/content.asp?hwid=cares)> [HealthLinkBC Website]

<sup>529</sup> Fraser Health, *Handbook for Caregivers* (April 2005) <[www.fraserhealth.ca/media/HandbookForCaregivers.pdf](http://www.fraserhealth.ca/media/HandbookForCaregivers.pdf)> [Fraser Health Handbook].

seniors with various health conditions.<sup>530</sup> The handbook also gives information on home and community care within the health authority, and community resources.<sup>531</sup>

### *Respite Care*

Some respite care is available through the home and community care program in BC. To be eligible for respite care, the care recipient must meet the general criteria for home and community care and the specific criteria for home support, and the caregiver must need a break from their care work.<sup>532</sup> There is a client rate applicable to respite care.<sup>533</sup> For residential respite care the client is charged a fixed rate of \$33 per day.<sup>534</sup>

Respite care is an overloaded system across Canada, leading to unmet needs. Health Canada conducted a survey of respite care in 2003 and found that there was overall a high demand for respite services.<sup>535</sup> In-home respite was the most requested respite service, and day programs were also much needed in most provinces, although the demand for day programs was only moderate in BC.<sup>536</sup> Residential respite care was used the least and thus was not as overburdened.<sup>537</sup> The most frequent respite users were spouses or children of the care recipient.<sup>538</sup> Health authorities often cited lack of money or personnel as the reason for the unmet need for respite care.<sup>539</sup> Lilly et al. in a descriptive study found caregivers most requested respite of all needed services for several reasons, including that respite was not available in rural areas, some caregivers did not know how to get respite, and some were unable to meet the requirements for receiving respite care.<sup>540</sup>

### *Direct Payments to Caregivers*

Some family members may be able to provide the government-funded home and community care to the care recipient under the Choice in Supports for Independent Living

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<sup>530</sup> Fraser Health Handbook, *ibid*.

<sup>531</sup> Fraser Health Handbook, *ibid* at 42-61.

<sup>532</sup> BC H&CC Website, *supra* note 436.

<sup>533</sup> BC H&CC Website, *ibid*.

<sup>534</sup> BC H&CC Policy Manual, *supra* note 16 at 7.C.1 1 of 1.

<sup>535</sup> Canada, Ministry of Health. *Respite for Family Caregivers An Environmental Scan of Publicly-funded Programs in Canada*. Prepared by Janet Dunbrack. (Ottawa: Health Canada, 2003), online: <[www.canada.ca/en/health-canada/services/health-care-system/reports-publications/home-continuing-care/respite-family-caregivers-environmental-scan-publicly-funded-programs-canada.html](http://www.canada.ca/en/health-canada/services/health-care-system/reports-publications/home-continuing-care/respite-family-caregivers-environmental-scan-publicly-funded-programs-canada.html)> [MOH Respite Study] at 1.

<sup>536</sup> *Ibid* at 1.

<sup>537</sup> *Ibid* at 6-8.

<sup>538</sup> *Ibid* at 4.

<sup>539</sup> *Ibid* at 1.

<sup>540</sup> Meredith B Lilly, Carole A Robinson, Susan Holtzman, & Joan L Bottorff, "Can we move beyond burden and burnout to support the health and wellness of family caregivers to persons with dementia? Evidence from British Columbia, Canada" (2012) 20:1 Health and Social Care in the Community 103 at 107.

(CSIL) program.<sup>541</sup> Care recipients who are determined to need home support and are able to manage their care on their own may receive the funds that their care would cost.<sup>542</sup> The client would then be responsible for finding, training, and monitoring the caregivers they hire, as well as complying with all employment laws and ensuring they receive a good quality of care.<sup>543</sup> Family members, with the exception of immediate family, can be paid with funds from CSIL.<sup>544</sup> An immediate family member is defined as a spouse, parent, or child.<sup>545</sup> The case manager must discuss with the client the risks that can occur by hiring a family member, such as harms to the caregiver's well-being, and conflicts of interest.<sup>546</sup> Health authorities may allow an immediate family member to provide the care if the client wants this, if there are no other caregivers available to provide this care, the risks associated with having an immediate family member care for the client are manageable, and the caregiver has respite built in to the care plan.<sup>547</sup> The BC Ombudsperson report found that few seniors were using this program, seniors did not know about the program, and going through the application process was difficult.<sup>548</sup>

### *Employment Leaves*

In BC, caregivers who are employed are eligible to take short-term leave to care for the health of their family members, which is called Family Responsibility Leave.<sup>549</sup> Under section 52 of the *Employment Standards Act (ESA)*<sup>550</sup> “[a]n employee is entitled to up to 5 days of unpaid leave during each employment year to meet responsibilities related to ...the care or health of any other member of the employee's immediate family.<sup>551</sup>” Employers are required to grant the leave if the employee meets the leave requirements.<sup>552</sup> Unused leave days do not carry over into the following year.<sup>553</sup> The care recipient must be an immediate family member who is defined in section 1 of the *ESA* as “(a) the spouse, child, parent, guardian, sibling, grandchild or

<sup>541</sup> BC H&CC Website, *supra* note 436.

<sup>542</sup> BC H&CC Website, *ibid*; Best of Care, *supra* note 16 at 40-41.

<sup>543</sup> BC H&CC Policy Manual, *supra* note 16 at 4.C.3 1 to 4 of 7.

<sup>544</sup> BC H&CC Policy Manual, *ibid* at 4.C.4 1 of 2.

<sup>545</sup> BC H&CC Policy Manual, *ibid* at 4.C.4 1 of 2.

<sup>546</sup> BC H&CC Policy Manual, *ibid* at 4.C.4 2 of 2.

<sup>547</sup> BC H&CC Policy Manual, *ibid* at 4.C.4 2 of 2.

<sup>548</sup> Best of Care, *supra* note 16 at 40-41.

<sup>549</sup> British Columbia, *Interpretation Guidelines Manual British Columbia Employment Standards Act and Regulations*, <[www2.gov.bc.ca/gov/content/employment-business/employment-standards-advice/employment-standards/igm/esa-part-6-section-52-1](http://www2.gov.bc.ca/gov/content/employment-business/employment-standards-advice/employment-standards/igm/esa-part-6-section-52-1)> [BC ESA Interpretation Guidelines] at s 52 Family Responsibility Leave.

<sup>550</sup> *Employment Standards Act*, RSBC 1996, c 113 [BC ESA].

<sup>551</sup> BC ESA, *ibid*, s 52.

<sup>552</sup> BC ESA Interpretation Guidelines, *supra* note 549 at s 52 Family Responsibility Leave; BC ESA, *ibid*, s 54.

<sup>553</sup> BC ESA Interpretation Guidelines, *ibid*.

grandparent of an employee, and (b) any person who lives with an employee as a member of the employee's family.”<sup>554</sup> The Family Responsibility Leave protects the employee from being fired or having their employment changed while they are on leave, and requires that an employee’s entitlement to vacation and other benefits such as pensions continue.<sup>555</sup>

In BC, employees also have access to a longer-term leave when a relative is terminally ill, which is called Compassionate Care Leave.<sup>556</sup> Under section 52.1 of the *ESA*, employees are entitled to eight weeks of unpaid leave within a 26 week period if they have a “family member [who] has a serious medical condition with a significant risk of death within 26 weeks.”<sup>557</sup> A family member is a part of the employee’s immediate family, which has the same definition as in the family responsibility leave,<sup>558</sup> and anyone else “who considers the employee to be, or whom the employee considers to be, like a close relative”.<sup>559</sup> This list of qualified relatives casts quite a wide net of family members for which one can take leave to care.

To go on Compassionate Care Leave, the employee only needs to notify their employer that they are going on the leave; this does not have to be in writing or in advance, and the employer cannot refuse the employee’s leave.<sup>560</sup> The employee must provide a certificate from a medical practitioner as soon as possible.<sup>561</sup> The certificate does not have to be obtained before the leave is taken to account for the fact that this leave may need to be taken without prior knowledge.<sup>562</sup> Leave must be taken in one week increments.<sup>563</sup> Like the Family Responsibility Leave, the Compassionate Care Leave protects employees from being fired or having their employment changed, and ensures the benefits and entitlements continue.<sup>564</sup>

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<sup>554</sup> BC *ESA*, *supra* note 550, s 1.

<sup>555</sup> BC *ESA*, *ibid*, s 54, 56.

<sup>556</sup> BC *ESA* Interpretation Guidelines, *supra* note 549 at s 52.1 Compassionate Care Leave.

<sup>557</sup> BC *ESA*, *supra* note 550, s 52.1(2).

<sup>558</sup> BC *ESA*, *ibid*, s 52.1(1) (In s 1 of the *ESA*, immediate family member is defined as “(a) the spouse, child, parent, guardian, sibling, grandchild or grandparent of an employee, and (b) any person who lives with an employee as a member of the employee's family” (s 1)).

<sup>559</sup> BC *ESA*, *ibid*, s 52.1(1); *Compassionate Care Leave Regulation*, BC Reg 281/2006 s 2. See the appendix for a list of the compassionate Care Leave regulations prescribed list of family members.

<sup>560</sup> BC *ESA*, *ibid*, s 52.1(2); BC *ESA* Interpretation Guideline, *supra* note 549 at S 52.1 Compassionate Care Leave

<sup>561</sup> BC *ESA*, *ibid*, s 52.1(2), (3); BC *ESA* Interpretation Guideline, *ibid*.

<sup>562</sup> BC *ESA*, *ibid*, s 52.1(2), (3), (5); BC *ESA* Interpretation Guidelines, *ibid*. The 26 week period begins either when the medical certificate is obtained by the employee or when the leave is first taken if the employee did not have the certificate prior to taking leave. The leave ends when the family member has died, when all eight weeks of leave have been taken, or when the 26 week period has ended (BC *ESA* s 52.1(2); BC *ESA* Interpretation Guideline).

<sup>563</sup> BC *ESA*, *ibid*, s 52.1(6); BC *ESA* Interpretation Guidelines, *ibid*.

<sup>564</sup> BC *ESA*, *ibid*, s 54, 56; BC *ESA* Interpretation Guidelines, *ibid*.

## Ontario Caregiver Supports

### *Government-provided Caregiver Information and Education*

The Ontario Government does have several websites with information for caregivers. The Temporary Respite Care for Caregiver webpage gives caregivers information on respite care.<sup>565</sup> The Home and Community Care information page also gives detailed information on the types of home care and how to apply for it.<sup>566</sup> Ontario Senior's Secretariat has produced a Guide to Programs and Services for Seniors in Ontario which gives seniors information on home care services, caregiver support services, and community resources.<sup>567</sup> This Guide includes a section for caregivers regarding tax credits and employment leaves.<sup>568</sup>

### *Respite Care*

In Ontario, caregivers may have access to two types of respite care, which the government provides to give caregivers “a break from the demands of caring for your loved one.”<sup>569</sup> In-home respite care provides a care worker coming into the home for a day or less.<sup>570</sup> For eligible care recipients, there is no fee for in-home respite care.<sup>571</sup>

Longer term respite care, called short-stay respite care, is provided in long-term care homes for a period of one to sixty days.<sup>572</sup> Short-stay respite care is provided in circumstances such as when the caregiver is away from home for a short period, or when the care recipient temporarily needs continuous care.<sup>573</sup> Clients can receive a maximum of 90 days of short-stay respite care per year.<sup>574</sup> Eligible care recipients must pay the accommodation costs of \$36.34 per day.<sup>575</sup> A Health Canada survey found that in-home and day program respite care was overburdened in Ontario with caregivers often placed on waitlists; this unmet need is due to most care for seniors happening in the community, as well as a lack of public resources to provide

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<sup>565</sup> Province of Ontario, “Temporary Respite Care for Caregivers” <[www.ontario.ca/page/temporary-respite-care-caregivers?\\_ga=1.187307247.675571647.1445550345](http://www.ontario.ca/page/temporary-respite-care-caregivers?_ga=1.187307247.675571647.1445550345)> [Ont Respite Care Website].

<sup>566</sup> Ont H&CC Website, *supra* note 20.

<sup>567</sup> Seniors' Secretariat Guide, *supra* note 21.

<sup>568</sup> Seniors' Secretariat Guide, *ibid.*

<sup>569</sup> Ont Respite Care Website, *supra* note 565.

<sup>570</sup> Ont Respite Care Website, *ibid.*

<sup>571</sup> Ont Respite Care Website, *ibid.*

<sup>572</sup> Ont Respite Care Website, *ibid.*

<sup>573</sup> Ont Respite Care Website, *ibid.*; O Reg 79/10 s 156(1).

<sup>574</sup> Ont Respite Care Website, *ibid.*

<sup>575</sup> Ont Respite Care Website, *ibid.*

these types of respite care.<sup>576</sup>

### *Employment Leaves*

In Ontario, caregivers who are employed have access to three different types of leaves under the *Employment Standards Act (ESA)*<sup>577</sup> - the Family Medical Leave, the Family Caregiver Leave, and the Personal Emergency Leave.<sup>578</sup> All of these are distinct leaves, and caregivers may be eligible for all three.<sup>579</sup> The Family Medical Leave allows caregivers to take an unpaid leave from their job of 8 weeks within a 26 week period to care for a family member who “has a serious medical condition with a significant risk of death occurring within a period of 26 weeks.”<sup>580</sup> To qualify, caregivers can provide physical or emotional care, or manage care provided by others.<sup>581</sup> Care recipients can be the caregiver’s spouse, parent, grandparent or others listed in the legislation and the regulations, and anyone who “considers the employee [caregiver] to be like a family member”.<sup>582</sup> The caregiver must obtain a medical certificate from a health practitioner.<sup>583</sup> Employees must notify their employer in writing they are taking this leave, as soon as possible after the leave has begun.<sup>584</sup>

All employees who are governed by the *ESA* are entitled to take Family Medical Leave; there are no requirements for length of employment or type of employment.<sup>585</sup> This leave is unpaid but it protects the employee from being terminated or penalized, and the employee’s benefits continue while on leave.<sup>586</sup> The employee must take leaves in one week increments.<sup>587</sup> There is one Family Medical Leave available for each care recipient, so if multiple family members wish to go on leave they must share the 8 weeks.<sup>588</sup>

Employed caregivers in Ontario also have access to the Family Caregiver Leave of 8

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<sup>576</sup> MOH Respite Study, *supra* note 535 at 6-8. See the above section on BC respite care for more detailed information.

<sup>577</sup> *Employment Standards Act, 2000*, SO 2000, c 41 [Ont ESA].

<sup>578</sup> Ont ESA, *ibid*, s 49.1, 49.3, 50.

<sup>579</sup> Ont ESA, *ibid*, ss 49.1(12), 49.3(9); Ontario Ministry of Labour, “Your Guide to the Employment Standards Act, 2000” (2015), online: <[www.labour.gov.on.ca/english/es/pubs/guide/](http://www.labour.gov.on.ca/english/es/pubs/guide/)> [Ont ESA Guide] at Family Medical Leave.

<sup>580</sup> Ont ESA, *supra* note 577, s 49.1(2).

<sup>581</sup> Ont ESA Guide, *supra* note 579 at Family Medical Leave.

<sup>582</sup> *O Reg 476/06* s 1(1); Ont ESA, *supra* note 577, s 49.1(3); the family medical leave regulation prescribes a wide range of relatives which would qualify including relatives by blood or marriage.

<sup>583</sup> Ont ESA, *ibid*, s 49.1(2), (10); Ont ESA Guide, *supra* note 579 at Family Medical Leave.

<sup>584</sup> Ont ESA, *ibid*, s 4.4(8)(9); Ont ESA Guide, *ibid*, at Family Medical Leave.

<sup>585</sup> Ont ESA Guide, *ibid*, at Family Medical Leave.

<sup>586</sup> Ont ESA Guide, *ibid*; Ont ESA, *supra* note 577, s 51.

<sup>587</sup> Ont ESA, *ibid*, s 49.1(7); Ont ESA Guide, *ibid*.

<sup>588</sup> Ont ESA, *ibid*, s 49.1(6); Ont ESA Guide, *ibid*.



weeks per calendar year.<sup>589</sup> The caregiver is “entitled to a leave of absence without pay to provide care or support to an individual ... if a qualified health practitioner issues a certificate stating that the individual has a serious medical condition.”<sup>590</sup> A serious medical condition is defined as “includ[ing] a condition that is chronic or episodic.”<sup>591</sup> The employee must be caring for one of the listed close family members, including the spouse, parent, or any other relative dependent on the caregiver, but this list of qualified relatives is much smaller than those which can qualify under Family Medical Leave.<sup>592</sup> Caregivers can be providing physical or emotional care, or managing the care provided by others.<sup>593</sup>

To access the leave, the caregiver must advise their employer that they are going on leave in writing as soon as possible after the leave is taken, and must give a copy of the medical certificate.<sup>594</sup> As long as the employed caregiver is covered by the *ESA*, they are eligible to take the leave, regardless of the type or length of employment.<sup>595</sup> Leave must be taken in one week increments.<sup>596</sup> This leave protects an employee from being fired or penalized, and allows for benefits to continue while on leave.<sup>597</sup>

Some employed caregivers may have access to the Personal Emergency Leave which allows the caregiver to take off 10 days per calendar year due to “the death, illness, injury or medical emergency”<sup>598</sup> or “an urgent matter”<sup>599</sup> of a relative.<sup>600</sup> The medical condition of the care recipient can be a pre-planned surgery if it is medically necessary.<sup>601</sup> An urgent matter can include an event which could cause emotional distress to a relative.<sup>602</sup> Caregivers can take time off to care for a close relative such as a spouse, parent, or any person dependent on the

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<sup>589</sup> Ont ESA Guide, *ibid* at Family Caregiver Leave; Ont *ESA*, *ibid*, s 49.3(2)(4).

<sup>590</sup> Ont *ESA*, *ibid*, s 49.3(2).

<sup>591</sup> Ont *ESA*, *ibid*, s 49.3(3).

<sup>592</sup> Ont ESA Guide, *supra* note 579 at Family Caregiver Leave; Ont *ESA*, *ibid*, s 49.3(5); there are no prescribed individuals in the regulations. See appendix for full list of relatives who qualify.

<sup>593</sup> Ont ESA Guide, *ibid* at Family Caregiver Leave.

<sup>594</sup> Ont *ESA*, *supra* note 577, s 49.3(6)(7)(8).

<sup>595</sup> Ont ESA Guide, *supra* note 579 at Family Caregiver Leave. Most individuals working in Ontario are covered by the *ESA*, with very limited exceptions such as those working for the federal government (Ont ESA Guide, at Who is not covered by the *ESA*).

<sup>596</sup> Ont ESA Guide, *ibid*.

<sup>597</sup> Ont ESA Guide, *ibid*; Ont *ESA*, *supra* note 577, s 51.

<sup>598</sup> Ont *ESA*, *ibid*, s 50(1).

<sup>599</sup> Ont *ESA*, *ibid*, s 50(1)

<sup>600</sup> Ont *ESA*, *ibid*, s 50(1)(5).

<sup>601</sup> Ont ESA Guide, *supra* note 579 at Personal Emergency Leave.

<sup>602</sup> Ont ESA Guide, *ibid* at Personal Emergency Leave..



employee.<sup>603</sup> The leave must be taken in one day increments.<sup>604</sup> To qualify, there is a requirement that the caregiver work for an employer who has at least 50 employees in all of their locations, regardless of their part-time or full-time status.<sup>605</sup> To take the leave, the caregiver must inform their employer as soon as possible.<sup>606</sup> This leave protects the employee from being fired or penalized, and benefits continue during this leave.<sup>607</sup>

### Other Provincial Caregiver Supports

For the most part in Canadian jurisdictions, there are no government payments directly to informal caregivers of the elderly.<sup>608</sup> However, Nova Scotia has a direct payment to caregivers called the Caregiver Benefit of \$400 per month.<sup>609</sup> The Caregiver Benefit Program Policy states that the reason for giving the Caregiver Benefit is “...to acknowledge their [the caregiver’s] contributions in providing assistance to a family member or friend and to assist the caregiver in sustaining the support they provide.”<sup>610</sup> To receive the benefit, the caregiver must be 19 years or older, a Nova Scotia resident with health care coverage, be providing at least 20 hours a week of care work, be providing care work for a long period of time, and not being paid to perform care work.<sup>611</sup> The care recipient must be a Nova Scotia resident with a valid health card, at least 19 years of age, require a high level of care, and have a low income.<sup>612</sup> The care must be provided by the same caregiver to the same care recipient, and only one caregiver can receive the benefit for each care recipient.<sup>613</sup> The program does allow funding to continue during interruptions of less than a month for circumstances such as the care recipient or caregiver being in the hospital or on vacation.<sup>614</sup> Receiving the Caregiver Benefit would not disqualify the care recipient from receiving home care, and the payment is not used to determine eligibility or income.<sup>615</sup>

<sup>603</sup> Ont ESA, *supra* note 577, s 50(2).

<sup>604</sup> Ont ESA, *ibid*, s 50(6); Ont ESA Guide, *supra* note 579 at Personal Emergency Leave.

<sup>605</sup> Ont ESA, *ibid*, s 50(1).

<sup>606</sup> Ont ESA, *ibid*, s 50(3)(4); Ont ESA Guide, *supra* note 579 at Personal Emergency Leave

<sup>607</sup> Ont ESA, *ibid*, s 51; Ont ESA Guide, *ibid*.

<sup>608</sup> BCLI, *supra* note 3 at 81-82.

<sup>609</sup> Province of Nova Scotia, “Caregiver Benefit” <[novascotia.ca/dhw/ccs/caregiver-benefit.asp](http://novascotia.ca/dhw/ccs/caregiver-benefit.asp)> [NS Caregiver Benefit Website]; Nova Scotia, Department of Health and Wellness Continuing Care Branch, *Caregiver Benefit Program Policy*, October 2012 Revision [Caregiver Benefit Program Policy] at 3.

<sup>610</sup> Caregiver Benefit Program Policy, *ibid* at 1.

<sup>611</sup> Caregiver Benefit Program Policy, *ibid* at 2.

<sup>612</sup> Caregiver Benefit Program Policy, *ibid* at 3; NS Caregiver Benefit Website, *supra* note 609: the care recipient’s household income must be \$22,125 or less if the care recipient is single, or \$37,209 or less if married or in a common law relationship.

<sup>613</sup> Caregiver Benefit Program Policy, *ibid* at 3-4.

<sup>614</sup> Caregiver Benefit Program Policy, *ibid* at 4.

<sup>615</sup> Caregiver Benefit Program Policy, *ibid* at 5.

Manitoba is the only jurisdiction to have created a *Caregiver Recognition Act (CRA)*.<sup>616</sup> The *CRA* defines a caregiver as “a person who provides informal and unpaid personal care, support or assistance to another person because that other person lives with challenges due to ... aging.”<sup>617</sup> The *CRA* creates a Caregiver Advisory Committee and requires the Minister to consult with caregivers.<sup>618</sup> The minister must report how the government is complying with this act, although “this act does not create rights or duties that are legally enforceable in court or other proceedings.”<sup>619</sup> Additionally, the *CRA* states eight general principles including that “the relationship between caregivers and the persons for whom they care should be recognized and respected”, recognizing the value of care work to society, and the need to support caregivers.<sup>620</sup> The latest government report on the *CRA* identified several new measures to help caregivers, including interdepartmental groups to aid caregivers employed by government, consultations with caregivers, public education campaigns, the annual Caregiver Recognition Day, and increases to caregiver tax credits.<sup>621</sup> The report listed new care work statistics and research.<sup>622</sup>

### **Federal Caregiver Supports**

#### *Compassionate Care Benefit*

Caregivers with a terminally ill relative who have taken time off their job to care for their relative may be eligible for the Compassionate Care Benefit through EI.<sup>623</sup> This program is similar to but separate from compassionate care leaves available in the provinces. Caregivers can qualify if they have “a family member ... [who] has a serious medical condition with a significant risk of death within 26 weeks”<sup>624</sup> and “the family member requires the care or support of one or more other family members.”<sup>625</sup> Caregivers must obtain a medical certificate, and submit this as soon as possible.<sup>626</sup> The caregiver can be providing emotional support, physical

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<sup>616</sup> *Caregiver Recognition Act*, CCSM c C24 [Man *CRA*].

<sup>617</sup> Man *CRA* s 1.

<sup>618</sup> Man *CRA*, s 7, 10.

<sup>619</sup> Man *CRA* s 8, 9(2), 11(1).

<sup>620</sup> Man *CRA*, Schedule.

<sup>621</sup> Manitoba, Seniors and Healthy Aging Secretariat, *Caregiver Recognition Act Report for the period, 2013-2015* (Winnipeg, Manitoba Health, Healthy Living and Seniors, 2015) at 6-7.

<sup>622</sup> *Ibid* at 8-10.

<sup>623</sup> Government of Canada, “EI Compassionate Care Benefit Overview” <[www.esdc.gc.ca/en/ei/compassionate/index.page](http://www.esdc.gc.ca/en/ei/compassionate/index.page)> [EI CC Website].

<sup>624</sup> *Employment Insurance Act*, SC 1996, c 23 [EIA] s 23.1(2)(a).

<sup>625</sup> EIA, *ibid*, s 23.1(2)(b)

<sup>626</sup> EIA, *ibid*, s 23.1(2), (3); SOR/96-332, s 41.2; EI CC Website, *supra* note 623.

care, or managing care provided by others.<sup>627</sup> There is a wide definition of family, including spouse, common law partner, parent, other relatives, and others the caregiver considers to be family.<sup>628</sup>

The family of the care recipient can only take a maximum of 26 weeks collectively.<sup>629</sup> These weeks can be taken all by one family member, or family members can each take a number of weeks off, either at the same time, or in different weeks.<sup>630</sup> In addition to the medical certificate requirements, applicants must also meet the general EI eligibility of having at least 40 percent less income due to caregiving responsibilities, and have worked at least 600 insured hours within the last year.<sup>631</sup> Eligible caregivers would receive 55 percent of their average insurable earnings up to the maximum of \$547 per week.<sup>632</sup>

In the 2017 budget, the government proposed to create a new 15 week EI benefit which would cover "...care to an adult family member who requires significant support in order to recover from a critical illness or injury."<sup>633</sup> Also, the government proposed to offer increased workplace flexibility to federal employees.<sup>634</sup>

#### *Federal Tax Credits*

There are federal tax credits which caregivers may receive for taking care of an elderly relative. The 2017 budget notes that the caregiver tax credit system was overly complex and proposed to consolidate these credits to a single Canada Caregiver Credit.<sup>635</sup> This credit is still non-refundable, but would cover caregivers who are not living with the care recipient.<sup>636</sup>

If the caregiver has a spouse or partner, child, or "parent, grandparent, brother, sister, uncle, aunt, niece, or nephew..." who has a mental or physical impairment and is dependent on the caregiver they can be eligible for this tax credit.<sup>637</sup> Dependency is defined as when the care

<sup>627</sup> SOR/96-332, s 41.1, EI CC Website, *ibid*.

<sup>628</sup> SOR/96-332, s 41.11(2); EI CC Website, *ibid*.

<sup>629</sup> EIA, *supra* note 624, s 23.1(8); SOR/96-332 s 41.3; EI CC Website, *ibid*.

<sup>630</sup> EIA, *ibid*, s 23.1(8); SOR/96-332, s 41.3; EI CC Website, *ibid*.

<sup>631</sup> EI CC Website, *ibid*.

<sup>632</sup> EI CC Website, *ibid*.

<sup>633</sup> 2017 Budget, *supra* note 222 at 63. The budget notes in its gender analysis that this will likely affect women most due to their higher levels of unpaid care than men (at 232).

<sup>634</sup> 2017 Budget, *ibid* at 64, 233.

<sup>635</sup> 2017 Budget, *ibid* at 204-206.

<sup>636</sup> 2017 Budget, *ibid*. The gender analysis notes this will help women more than men since they provide more of the care (at 241).

<sup>637</sup> Canada, "The New Caregiver Tax Credit", online: < [www.canada.ca/en/revenue-agency/services/tax/individuals/topics/about-your-tax-return/tax-return/completing-a-tax-return/deductions-credits-expenses/family-caregiver-amount.html?utm\\_campaign=not-applicable&utm\\_medium=vanity](http://www.canada.ca/en/revenue-agency/services/tax/individuals/topics/about-your-tax-return/tax-return/completing-a-tax-return/deductions-credits-expenses/family-caregiver-amount.html?utm_campaign=not-applicable&utm_medium=vanity)

recipient does “... depend on you for support if they rely on you to regularly and consistently provide them with some or all of the basic necessities of life, such as food, shelter and clothing.”<sup>638</sup> To claim the federal tax credits, there is no requirement for the number of hours of care work that needs to be given to the care recipient.<sup>639</sup> A medical certificate may be required describing the impairment and how long the dependent is likely to need care.<sup>640</sup> These tax credits are non-refundable, which means that the amount is deducted from the taxes that the caregiver owes each year.<sup>641</sup> However, if the amount of income the caregiver earned was too low such that the credit did not need to be fully used to reduce the owed taxes, then the leftover credit amount does not get used or refunded.<sup>642</sup>

The CCC is an additional amount that can be received if the caregiver would receive one other care-related tax credit.<sup>643</sup> The CCC can be an addition to the spouse or common law partner amount or for another eligible adult dependent:

If you are eligible for the Canada caregiver amount for your spouse or common-law partner, or an eligible dependant 18 years of age or older, and his or her net income is between \$6,902 and \$23,046, you may be able to claim an amount up to a maximum of \$6,883. However, you must first claim the amount of \$2,150 in calculating the spouse or common-law partner amount on line 303; or the amount on line 305 for an eligible dependant 18 years of age or older.<sup>644</sup>

### *Flexible Working Arrangements*

The Canadian Human Rights Commission in 2014 brought out a guide on how employers can help employees balance paid work and care work.<sup>645</sup> The report describes how employers must accommodate an employee’s needs to care for family by discussing it, coming up with a plan on how this can best be accommodated, and allowing for changes as caregiving needs

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url&utm\_source=canada-ca\_caregiver-credit> [CCC Website]. *Income Tax Act*, RSC 1985, s 1 (5th Supp) [ITA] s 118.

<sup>638</sup> CCC Website, *ibid*.

<sup>639</sup> BCLI, *supra* note 3 at 73.

<sup>640</sup> CCC Website, *supra* note 637.

<sup>641</sup> BCLI, *supra* note 3 at 67.

<sup>642</sup> BCLI, *ibid*.

<sup>643</sup> CCC Website, *supra* note 637.

<sup>644</sup> Canada, “Line 304 - Canada caregiver amount for spouse or common-law partner, or eligible dependant age 18 or older”, online: < [www.canada.ca/en/revenue-agency/services/tax/individuals/topics/about-your-tax-return/tax-return/completing-a-tax-return/deductions-credits-expenses/line-304-caregiver-spouse-dependant.html](http://www.canada.ca/en/revenue-agency/services/tax/individuals/topics/about-your-tax-return/tax-return/completing-a-tax-return/deductions-credits-expenses/line-304-caregiver-spouse-dependant.html)>

<sup>645</sup> Canada, Canadian Human Rights Commission. *A Guide to Balancing Work and Caregiving Obligations* (Ottawa: Minister of Public Works and Government Services, 2014), online: <[www.chrc-ccdp.gc.ca/eng/content/guide-balancing-work-and-caregiving-obligations](http://www.chrc-ccdp.gc.ca/eng/content/guide-balancing-work-and-caregiving-obligations)> [CHRC Guide].

change.<sup>646</sup> However, the report notes that the employer does not need to accommodate if doing so will cause undue hardship, and there is no set criteria for determining when the threshold is met.<sup>647</sup> The caregiver also has a burden to prove that she had no other option for care other than to ask for her employer to accommodate her, that she has tried to make other arrangements, and that she truly had no choice but to engage in caregiving, as her workplace does not have to accommodate her if she is voluntarily choosing to care.<sup>648</sup>

### **Community Caregiver Information**

Community organizations and support groups do exist to help caregivers. These are usually groups of caregivers assisting other caregivers with emotional and social support and sharing resources. For example The Family Caregiver and The Caregiver Exchange are both websites where caregivers share information and resources.<sup>649</sup> Organizations such as Family Caregivers of British Columbia and United Way of Lower Mainland have handbooks and printed material on how to care for seniors, and the Family Caregivers of BC hosts support groups and phone support lines.<sup>650</sup> Ontario's Caregiver Coalition is a group which has caregiver resources and also advocates for increasing supports for informal caregivers.<sup>651</sup>

### **Discrimination Protection**

Caregivers do have access to protection from discrimination. The *BC Human Rights Code* (BC HRC)<sup>652</sup> provides that employers cannot “refuse to employ or refuse to continue to employ a person, or ... discriminate against a person regarding employment or any term or condition of employment because of the ... family status...” of the employee.<sup>653</sup> There are not yet any cases applying section 13 of the BC HRC to the situation of caring for the elderly, so it is yet known whether this could be applied to the situation of an employee being discriminated against due to their responsibilities of caring for elderly family members.<sup>654</sup> The Ontario *Human*

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<sup>646</sup> *Ibid* at 6-9.

<sup>647</sup> *Ibid* at 4.

<sup>648</sup> *Ibid* at 5-6.

<sup>649</sup> The Family Caregiver.com <[www.thefamilycaregiver.com/ontario/caregiving/caregiving.php](http://www.thefamilycaregiver.com/ontario/caregiving/caregiving.php)>; The Caregiver Exchange.ca <<http://www.caregiverexchange.ca/>>.

<sup>650</sup> Family Caregivers of British Columbia: <[www.familycaregiversbc.ca/](http://www.familycaregiversbc.ca/)>; United Way of the Lower Mainland, *Family & Friend Caregivers Information and Resource Handbook* (2016) <[www.uwlm.ca/resources/caregivers-information-and-resources-handbook/](http://www.uwlm.ca/resources/caregivers-information-and-resources-handbook/)>.

<sup>651</sup> Ontario Caregiver Coalition: <<http://www.ontariocaregivercoalition.ca/>>.

<sup>652</sup> *Human Rights Code*, RSBC 1996, c 210 [BC HRC].

<sup>653</sup> BC HRC, s 13(1).

<sup>654</sup> BC HRC, *ibid*, s 1, 13; BCLI, *supra* note 3 at 41-42; a search of court cases found that the only decisions relating to family status under s 13 of the HRC were on matters of caring for children or maternity/pregnancy leave.

*Rights Code*<sup>655</sup> does provide for protection against discrimination in employment due to family status.<sup>656</sup> Section 5(1) states that “[e]very person has a right to equal treatment with respect to employment without discrimination because of ... family status...”<sup>657</sup> Family status is defined in section 10 as “the status of being in a parent and child relationship”<sup>658</sup> A search of cases on discrimination on family status did not result in any cases on family status relating to care of an elderly individual. Given the lack of cases involving caring for an adult family member, it is difficult to fully examine what would happen if a claim were brought for care of an elderly family member; additionally, a full examination of the case law of discrimination claims solely under the umbrella of disability, not family status, is beyond the scope of this work.

### Conclusion

This chapter has examined home care, and supports for caregivers in Canada. Home care, such as nursing, personal care, and day programs, is available in BC and Ontario, but only fills the gap where individuals do not have informal care.<sup>659</sup> There is evidence for many seniors having unmet need for formal care, although this has been hard to measure in studies.<sup>660</sup> In BC, supports include some limited information for caregivers, in-home respite, the CSIL program to pay some informal caregivers, and short leaves for caring for elder family members with chronic illnesses.<sup>661</sup> In Ontario, supports similarly include information for caregivers, respite, and employment leaves.<sup>662</sup> Nova Scotia has a direct payment for caregivers at \$400 per month and Manitoba has a Caregiver Recognition Act.<sup>663</sup> The federal government provides a paid compassionate care leave through the EI program, tax credits, and flexible work arrangements for federal employees.<sup>664</sup> The next chapter describes what home care and caregiver supports are available in Australia, to be compared to Canada in the analysis chapter.

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<sup>655</sup> *Human Rights Code*, RSO 1990, c H19 [Ont HRC].

<sup>656</sup> Ont HRC, *ibid*, s 5(1).

<sup>657</sup> Ont HRC, *ibid*, s 5(1).

<sup>658</sup> Ont HRC, *ibid*, s 10(1).

<sup>659</sup> BC H&CC Website, *supra* note 436; Ont H&CC Website, *supra* note 20.

<sup>660</sup> Hoover & Rotermann, *supra* note 519; Turcotte, Unmet Needs, *supra* note 26; Sinha & Bleakney, *supra* note 521; CIHI, Seniors in Transition, *supra* note 524.

<sup>661</sup> Caring for Seniors Website, *supra* note 527; Fraser Health Handbook, *supra* note 529; BC H&CC Website, *ibid*; Best of Care, *supra* note 16; BC ESA, *supra* note 550.

<sup>662</sup> Ont Respite Care Website, *supra* note 565; Ont H&CC Website, *supra* note 20; Seniors; Secretariat Guide, *supra* note 21; Ont ESA, *supra* note 577; Ont ESA Guide, *supra* note 579.

<sup>663</sup> NS Caregiver Benefit Website, *supra* note 609; Man CRA, *supra* note 616.

<sup>664</sup> EI CC Website, *supra* note 623; CCC Website, *supra* note 637; CHRC Guide, *supra* note 645.



## CHAPTER FIVE: AUSTRALIA'S HOME CARE SYSTEM AND SUPPORTS FOR INFORMAL CAREGIVERS

This chapter examines the legislation for home and community care and caregiver supports in Australia. First, the Commonwealth's home care programs is described, including public information, and a note about the legislation that underlies these programs. Second, I survey what government supports are available to informal caregivers of the elderly in Australia, including supports from the states and territories, and government-funded community supports.

### Commonwealth Home and Community Care Program

The Australian health care system is similar to Canada, with a few key differences. In Australia, there is a publicly funded health care system, and also a private system which residents can choose to use.<sup>665</sup> For the public system, the federal Commonwealth government runs the medical insurance plan for the country, as well as setting general health care policies and laws, among other health care programs.<sup>666</sup> The Commonwealth government also is in charge of the “subsidies for aged care services, such as residential care and regulation of the aged care sector.”<sup>667</sup> The states and territories deliver the public health care, such as hospital services. This thesis will focus on the federal regulation of aged care.<sup>668</sup>

In Australia, the Commonwealth government manages the aged care system, primarily under the *Aged Care Act 1997 (ACA)*, making care a federal responsibility.<sup>669</sup> The objectives of the act include ensuring effective, accessible, and flexible aged care, ensuring the aged can age in place, and providing respite for carers.<sup>670</sup> There are three main types of care which are provided to seniors, which are in-home care, aged care homes, and transition care, discussed in more detail below.<sup>671</sup> In-home care provides services to aid seniors in remaining in their community, and is

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<sup>665</sup> Australia, Parliament of Australia, “Health in Australia: a quick guide”, by Amanda Biggs, Social Policy (6 November 2013), online: <[www.aph.gov.au/About\\_Parliament/Parliamentary\\_Departments/Parliamentary\\_Library/pubs/rp/rp1314/QG/HealthAust](http://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/rp/rp1314/QG/HealthAust)>.

<sup>666</sup> *Ibid.*

<sup>667</sup> *Ibid.*

<sup>668</sup> *Ibid.*

<sup>669</sup> ACA, *supra* note 160.

<sup>670</sup> ACA, *ibid.*, s 2-1; Australian Government, Department of Social Services: “Guide to Aged Care Law” (Version 1.10, 2016), online: <[guides.dss.gov.au/guide-aged-care-law](http://guides.dss.gov.au/guide-aged-care-law)> [DSS, Guide to Aged Care Law].

<sup>671</sup> My Aged Care Website, *supra* note 159 at What Help can I Get?



provided through either the Commonwealth Home Support Program or the Home Care Package.<sup>672</sup> Aged care homes provide accommodations and personal and medical care available on a continuous basis.<sup>673</sup> Transition care provides some basic health services for those who have just been discharged from hospital but need some health care services for a short period of time.<sup>674</sup> The government also provides some types of respite care, discussed below.<sup>675</sup>

### In-Home Care

Home care is defined by the *Aged Care Act* as “...a package of personal care services and other personal assistance provided to a person who is not being provided with residential care.”<sup>676</sup> The array of in-home care services includes health services such as nursing and physiotherapy to help with minor health conditions and general well-being.<sup>677</sup> Care recipients can also receive personal care such as help bathing, grooming, and moving around the home.<sup>678</sup> In-home care provides help around the home including general cleaning, minor home maintenance, and modifications to help the care recipient be safer and move around the home better. Instrumental help can be provided, such as assistance with food preparation, shopping, transportation, and provision of mobility and health supplies.<sup>679</sup> Eligible care recipients can receive social visits or counselling and support services.<sup>680</sup>

In-home care services are provided under two umbrellas – the Commonwealth Home Support Program, or the Home Care Package.<sup>681</sup> The Home Support Program is for care recipients who need a lower level of care to stay in their home or community.<sup>682</sup> Care recipients are assessed by the Regional Assessment Service to determine what kind of care they would be eligible for.<sup>683</sup> Under this program, care recipients can receive care such as help around the house, personal care, and health care services.<sup>684</sup> To be eligible for this program, the care recipient must be 65 years of age or older, living at home, and need some assistance to remain in

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<sup>672</sup> My Aged Care Website, *ibid* - the Home Support Program and Home Care Package will be discussed in detail in the in-home care section.

<sup>673</sup> My Aged Care Website, *ibid*.

<sup>674</sup> My Aged Care Website, *ibid*.

<sup>675</sup> My Aged Care Website, *ibid*.

<sup>676</sup> *ACA*, *supra* note 160 at s 45-3(1).

<sup>677</sup> My Aged Care Website, *supra* note 159 at Help at Home.

<sup>678</sup> My Aged Care Website, *ibid*.

<sup>679</sup> My Aged Care Website, *ibid*.

<sup>680</sup> My Aged Care Website, *ibid*.

<sup>681</sup> My Aged Care Website, *ibid*.

<sup>682</sup> My Aged Care Website, *ibid*.

<sup>683</sup> My Aged Care Website, *ibid*.

<sup>684</sup> My Aged Care Website, *ibid*.

their home.<sup>685</sup> The government provides and subsidises the home support program, although care recipients must contribute to their care unless they are unable to financially.<sup>686</sup>

The Home Care Package is for those care recipients who need a higher level of care, and the services are more tailored to the specific needs of the client.<sup>687</sup> Care recipients are assessed by the Aged Care Assessment Team, and determined to need one of four levels of care, or packages.<sup>688</sup> To be eligible for a home care package, the care recipient can be any age including less than 65 years, and must be living at home, but need help in order to remain there.<sup>689</sup> The client's services will be tailored to their specific needs.<sup>690</sup> The assessment process for a home care package is more detailed than for the home support program, and includes an assessment of the care recipient and discussions with their health care professionals.<sup>691</sup>

To receive both a Home Care Package or a Commonwealth Home Support Program, the care recipients contact a My Aged Care centre where staff will discuss the care recipient's situation, create a client record, and have the care recipient assessed by the appropriate staff.<sup>692</sup> Once a care recipient has been approved for aged care services by the appropriate assessment team, they must get referred to a service provider.<sup>693</sup> Care recipients are allowed to choose which service provider they wish to have, or they can go to the next available provider.<sup>694</sup> However, waiting for a specific service provider can lead to a long waiting time.<sup>695</sup>

If there are no available service providers in the area, the care recipient will be placed on a waitlist.<sup>696</sup> Service providers each have their own waitlists if their services are full; the aged care program encourages providers to order their waitlists based on care needs, although they are free to order the waitlist using any criteria, such as by order of contacting the care provider.<sup>697</sup>

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<sup>685</sup> My Aged Care Website, *ibid*; ACA, *supra* note 160 at s 21-3; ACRP, *supra* note 160 at s 7.

<sup>686</sup> My Aged Care Website, at Help at Home, *ibid*.

<sup>687</sup> My Aged Care Website, *ibid*; Australian Government, Department of Social Services, "Five steps to accessing a Home Care Package" (Canberra: Department of Social Services, 2015), online: <agedcare.health.gov.au/programs-services/home-care/five-steps-to-accessing-home-care-packages> [DSS, 5 Steps to HCP] at 6.

<sup>688</sup> My Aged Care Website, at Help at Home, *ibid*; DSS, 5 Steps to HCP, *ibid* at s 6, 10-13; ACRP, *supra* note 160 at s 7; ACA, *supra* note 160 at s 22-3, 22-4, 22-6.

<sup>689</sup> My Aged Care Website, *ibid*; ACA, *ibid* at s 21-3; ACRP, *ibid* at s 7.

<sup>690</sup> My Aged Care Website, *ibid*; DSS, 5 Steps to HCP, *supra* note 687 at 6.

<sup>691</sup> My Aged Care Website, *ibid*; DSS, 5 Steps to HCP, *ibid* at 10-13.

<sup>692</sup> My Aged Care Website, *ibid*; DSS, 5 Steps to HCP, *ibid* at 8-9.

<sup>693</sup> My Aged Care Website, *ibid* at What Help Can I Get?

<sup>694</sup> My Aged Care Website, *ibid*; DSS, 5 Steps to HCP, *supra* note 687 at 14.

<sup>695</sup> My Aged Care Website, *ibid*.

<sup>696</sup> My Aged Care Website, *ibid*. See the next section on use of the formal health care system for data on unmet need.

<sup>697</sup> DSS, 5 Steps to HCP, *supra* note 687 at 15.

Most care recipients are expected to contribute to the cost of their aged care, although there are government subsidies available for eligible clients.<sup>698</sup> The amount of subsidy the care recipient receives will be determined when they are given their care program or package.<sup>699</sup> The subsidy is paid directly to the care provider.<sup>700</sup> For those in the Home Care Package, the care plan must include a budget which sets out the subsidy and the fees to be paid by the client; monthly statements are then sent to the client setting out the exact expenditures.<sup>701</sup>

For the Commonwealth Home Support Program, the service provider and care recipient will make an agreement on the cost of care services.<sup>702</sup> For the Home Care Package, there is a daily fee which can be a maximum of A\$139.02 per two weeks.<sup>703</sup> If the client has an income above a certain amount, they will be asked to pay an additional income-tested care fee, up to the annual lifetime cap.<sup>704</sup> The care recipient's income must be above A\$25,792.00 for an individual or A\$40,050.40 for a couple residing together to be asked to pay the income-tested care fee.<sup>705</sup>

#### Transition Care

If care recipients have been discharged from the hospital and are able to go home but need some short-term health services to continue recovering, they may be eligible for transition care, or after-hospital care.<sup>706</sup> Transition care is only provided for a short period of time up to 12 weeks.<sup>707</sup> Services are limited to health care such as nursing and physical therapy, and are provided within the home.<sup>708</sup> Like other in-home care services, subsidies are available for

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<sup>698</sup> My Aged Care Website, *supra* note 159 at Help at Home; DSS, 5 Steps to HCP, *ibid* at 16; ACA, *supra* note 160 at s 52D-1.

<sup>699</sup> My Aged Care Website, *ibid*; DSS, Guide to Aged Care Law, *supra* note 670; ACA, *ibid* at s 48-1, 48-2. The current home care package subsidies range from A\$22.04 to A\$133.99 per day depending on the package level: Australian Government, Department of Health, "Aged Care Subsidies and Supplements New Rates of Payment from 1 January 2017", online: <agedcare.health.gov.au/funding/aged-care-fees-and-charges/aged-care-subsidies-and-supplements-new-rates-of-payment-from-01-january-2017 > [DOH, Aged Care Subsidies] at 1.

<sup>700</sup> DSS, 5 Steps to HCP, *supra* note 687 at 20; DSS, Guide to Aged Care Law, *ibid*; ACA, *ibid* at s 48-1(1).

<sup>701</sup> DSS, 5 Steps to HCP, *ibid* at 25-27; *User Rights Principles 2014* (Cth) at s 21A, 21B; DSS, Guide to Aged Care Law, *supra* note 670.

<sup>702</sup> My Aged Care Website, *supra* note 159 at Help at Home.

<sup>703</sup> ACA, *supra* note 160 at s 52D-1, 52D-2, 52D-3; My Aged Care Website, *ibid*; DSS, 5 Steps to HCP, *supra* note 687 at 17. (The daily fee is set at a maximum of 17.5% of the basic age pension – DSS 5 Steps to HCP at 17, ACA s 52D-3).

<sup>704</sup> My Aged Care Website, *ibid*; DSS, 5 Steps to HCP, *ibid* at 17; ACA, *ibid* at s 48-7; 52D-2.

<sup>705</sup> My Aged Care Website, *ibid*.

<sup>706</sup> My Aged Care Website, *ibid*; ACA, *supra* note 160 at s 21-4, 49-3; ACRP, *supra* note 160 at s 8.

<sup>707</sup> *Subsidy Principle 2014* (Cth) at s 111(5); My Aged Care Website, *ibid*: services can be extended for an additional 6 weeks if the care recipient is assessed as needing this further care.

<sup>708</sup> My Aged Care Website, *ibid*.

eligible clients, but clients are expected to contribute towards the daily fee.<sup>709</sup> The daily fee is a maximum of A\$48.44 for transition care in residence care and \$9.97 for home care.<sup>710</sup>

### Use of the Formal Health Care System

In 2015, there were approximately 3.5 million seniors in Australia.<sup>711</sup> The senior population in Australia has been increasing from 12.6% of the population in 2003 to 15.1% in 2015.<sup>712</sup> The ABS survey found that 87% of seniors had a long-term health condition, which has remained consistent with previous surveys.<sup>713</sup> Seniors often need care or assistance in their daily lives – the ABS survey found that 42% of seniors required some form of assistance or care.<sup>714</sup> This care was most often health care, keeping up their home, personal care, and moving around the home.<sup>715</sup> The ABS survey found that elderly Australians receive formal care services about evenly from government and private companies.<sup>716</sup> For the Commonwealth Home Support Program for the 2015-2016 year, the government is projected to spend \$1.6 billion on the program, and over 500,000 seniors use the program each year.<sup>717</sup>

Caregivers utilize formal health services, both for themselves and for the care recipient. The ABS survey found that 38% of carers reported having some formal care for the care recipient, although the bulk of the assistance came from other informal carers.<sup>718</sup> Over half of care recipients felt that they did not have adequate help.<sup>719</sup> Studies have found carers do not know about what formal care services are available.<sup>720</sup> Carers also use more formal care services for themselves, particularly when caring changes, such as becoming a co-resident carer.<sup>721</sup> This shows that there is also some unmet need for formal care in Australia.

### Carer Recognition Legislation

In Australia, the Commonwealth has enacted carer recognition legislation to recognize

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<sup>709</sup> My Aged Care Website, *ibid*; ACA, *supra* note 160 at s 50-1, 50-2, 52-1; *Subsidy Principles*, *supra* note 707 at s 101, 103, 106, 111.

<sup>710</sup> My Aged Care Website, *ibid*.

<sup>711</sup> ABS, 2015 DAC Survey, *supra* note 162.

<sup>712</sup> ABS, 2015 DAC Survey, *ibid*; ABS, 2012 DAC Survey, *supra* note 162.

<sup>713</sup> ABS, 2012 DAC Survey, *ibid*.

<sup>714</sup> ABS, 2012 DAC Survey, *ibid*.

<sup>715</sup> ABS, 2012 DAC Survey, *ibid*.

<sup>716</sup> ABS, 2012 DAC Survey, *ibid*.

<sup>717</sup> Australian Government, Department of Health, “Ageing and Aged Care Section”, online: <agedcare.health.gov.au/> [DOH, Aged Care]; My Aged Care Website, *supra* note 158 at Help at Home.

<sup>718</sup> ABS, 2012 DAC Survey, *supra* note 162; ABS, Caring in the Community, *supra* note 161.

<sup>719</sup> ABS, Caring in the Community, *ibid*.

<sup>720</sup> ABS, Caring in the Community, *ibid*; Stockwell-Smith et al., *supra* note 183 at 2062.

<sup>721</sup> McKenzie et al., *supra* note 183 at 324-326.

the informal carer's role, and to set out guiding principles for government to follow in aiding carers.<sup>722</sup> Most states have their own similar carer recognition legislation which will be discussed below.<sup>723</sup> The *Carer Recognition Act 2010 (CRA)* states that its purpose is to “increase recognition and awareness of carers and to acknowledge the valuable contribution they make to society.”<sup>724</sup> The guideline for public service agencies notes that this act is to create “...cultural and attitudinal changes”<sup>725</sup> in government agencies.<sup>726</sup> A carer is defined under this legislation as someone providing “personal care, support and assistance”<sup>727</sup> to a person who has an illness, disability, or is frail and aged.<sup>728</sup> Care work cannot be provided for pay or as a volunteer for an organisation, or as part of one's education.<sup>729</sup> This act is to be understood by all government agencies who deal with informal carers, and policy development must include carers and reflect the carer statement.<sup>730</sup> Government organisations must develop internal employee policies to support employee carers.<sup>731</sup> Public service care agencies must report annually on how they are complying with this act.<sup>732</sup> However, this act specifically states that it does not create any legal obligations.<sup>733</sup> This act is limited to supports that are targeted solely toward carers, not to broader health policies and programs that may impact carers.<sup>734</sup>

Schedule 1 sets out the statement for carers, which includes providing carers with supports to help their health and economic circumstances, and ensuring carers are treated with respect and be given equal opportunities as non-carers.<sup>735</sup> The carer statement recognizes the

<sup>722</sup> Australian Government, “Carer Gateway”, online: <[www.carergateway.gov.au/](http://www.carergateway.gov.au/)> [Carer Gateway Website].

<sup>723</sup> Carer Gateway Website, *ibid*.

<sup>724</sup> *Carer Recognition Act 2010 (Cth)* [Cth CRA].

<sup>725</sup> Australian Government, Department of Social Services, “Carer Recognition Act 2010 Guidelines” (2016), online: <[www.dss.gov.au/our-responsibilities/disability-and-carers/publications-articles/carers-recognition-act-2010-guidelines](http://www.dss.gov.au/our-responsibilities/disability-and-carers/publications-articles/carers-recognition-act-2010-guidelines)> [DSS, CRA Guidelines] at 2.

<sup>726</sup> DSS, CRA Guidelines, *ibid*.

<sup>727</sup> Cth CRA, *supra* note 724 at s 5.

<sup>728</sup> Cth CRA, *ibid* at s 5.

<sup>729</sup> Cth CRA, *ibid* at s 5.

<sup>730</sup> Cth CRA, *ibid* at s 7, 8.

<sup>731</sup> Cth CRA, *ibid* at s 7.

<sup>732</sup> Cth CRA, *ibid* at s 8; DSS, CRA Guidelines, *supra* note 725: public service agencies and associated providers are excluded from reporting obligations.

<sup>733</sup> Cth CRA, *ibid* at s 10.

<sup>734</sup> DSS, CRA Guidelines, *supra* note 725.

<sup>735</sup> Cth CRA, *supra* note 724 at Sch 1. The CRA does not further specify what type of activities carers should have equal opportunities as those who are not caring. The statement says “All carers should have the same rights, choices and opportunities as other Australians, regardless of age, race, sex, disability, sexuality, religious or political beliefs, Aboriginal or Torres Strait Islander heritage, cultural or linguistic differences, socioeconomic status or locality.” (Cth CRA, Sch 1).

diversity in carers, including young carers and Aboriginal carers.<sup>736</sup> Carers are to be treated as “partners with other care providers in the provision of care, acknowledging the unique knowledge and experience of carers.”<sup>737</sup> The act recognises both carers as “individuals with their own needs within and beyond the caring role”<sup>738</sup> and recognises “the relationship between carers and the person for whom they care for...”<sup>739</sup> The Department of Social Services (DSS) guidelines for public service agencies suggests including carer bodies in policy and legislation consultation.<sup>740</sup> To support employee carers, the guidelines suggest employers create support groups, and educate managers on work flexibility.<sup>741</sup>

Government departments do seem to be reporting under the CRA within their annual reports. The Department of Human Services (DHS) and DSS put a small appendix in with their yearly update, and the Department of Health (DOH) included a section within the body of their annual report.<sup>742</sup> The DSS and DHS put information up on their local intranet sites for staff, and stated they gave flexible work arrangements and help through their employee assistance plans.<sup>743</sup> The DOH went further developing carers groups and allowing carers more employment benefits such as free counseling, additional leave, and having a family care room.<sup>744</sup> The DHS also promoted information to the public such as taking part in the National Carers Week and producing newsletters.<sup>745</sup> The DSS and DOH included carers and carer organizations in redeveloping programs that impact carers such as the Carer Gateway and palliative services.<sup>746</sup>

The majority of states and territories in Australia have also enacted carer recognition acts,<sup>747</sup> with the exception of Tasmania, which has a Carer Policy<sup>748</sup>, and the Australian Capital

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<sup>736</sup> Cth CRA, *ibid* at Sch 1.

<sup>737</sup> Cth CRA, *ibid* at Sch 1.

<sup>738</sup> Cth CRA, *ibid* at Sch 1.

<sup>739</sup> Cth CRA, *ibid* at Sch 1.

<sup>740</sup> DSS, CRA Guidelines, *supra* note 725 at 6-7.

<sup>741</sup> DSS, CRA Guidelines, *ibid* at 4-5.

<sup>742</sup> Australia, Commonwealth, Department of Social Services, *Annual Report 2015-16* at 228-229; Australia, Commonwealth, Department of Human Services, 2015-16 *Annual Report* (Canberra: Department of Human Services, 2016) at 231-232; Australia, Commonwealth, Department of Health, *Annual Report 2015-2016* (Canberra: Department of Health, 2016) at 276-280.

<sup>743</sup> DSS Annual Report, *ibid*; DHS Annual Report, *ibid*.

<sup>744</sup> DOH Annual Report, *supra* note 742.

<sup>745</sup> DHS Annual Report, *supra* note 742.

<sup>746</sup> DSS Annual Report, *supra* note 742; DOH Annual Report, *supra* note 742.

<sup>747</sup> *Carers (Recognition) Act 2010* (NSW) [NSW CRA]; *Carers Recognition Act 2012* (Vic) [Vic CRA]; *Carers Recognition Act 2005* (SA) [SA CRA]; *Carers (Recognition) Act 2008* (Qld) [Qld CRA]; *Carers Recognition Act 2004* (WA) [WA CRA]; *Carers Recognition Act* (NT) [NT CRA].

<sup>748</sup> Tasmanian Government, Department of Premier and Cabinet, “Tasmanian Carer Policy 2013”, online: <[www.dpac.tas.gov.au/divisions/csr/policy/Policy\\_Work/carers\\_policy\\_and\\_action\\_plan](http://www.dpac.tas.gov.au/divisions/csr/policy/Policy_Work/carers_policy_and_action_plan)> [Tas Carer Policy].



Territory which has a carer's charter.<sup>749</sup> All of the acts have a purpose of recognising the contributions of carers,<sup>750</sup> and the Victoria and South Australia acts also were created with the purpose of supporting carers.<sup>751</sup> All of the acts define carers similar to the Commonwealth act, as those providing unpaid assistance to people with an illness, disability, or frail elderly.<sup>752</sup> New South Wales, Victoria, and Queensland also note that their acts do not create any legal obligations.<sup>753</sup> This means that carers do not have any legal avenue under this act to enforce the government complying with this act or get compensation for breaches. All of the acts except Victoria's act require organisations interacting with carers to understand what is in the act, and to consult with carers on policy that impacts carers.<sup>754</sup> All of the acts require organisations to report on whether they are following the act.<sup>755</sup> New South Wales, Queensland, and Western Australia have created a Carers Advisory Council.<sup>756</sup> Each of the acts outline a carers charter setting out principles on how carers are to be treated, which include similar principles to the Commonwealth act such as recognising the value of the contribution carers make to society, respecting carers, and considering carer's views.<sup>757</sup>

### **Government-Provided Information for Caregivers**

There are several websites created by the Australian Commonwealth government with information on caring, carer supports, and home and community care. The Australian

<sup>749</sup> Australian Capital Territory Government, "Carers Charter Postcard", online: <[www.communityservices.act.gov.au/ocyfs/caring\\_for\\_carers](http://www.communityservices.act.gov.au/ocyfs/caring_for_carers)> [ACT Charter Postcard] – the carers charter seeks to recognise carer's contributions, and its principles include that carers should be consulted, treated with respect, and supported.

<sup>750</sup> NSW CRA, *supra* note 747 at s 3; Vic CRA, *supra* note 747 at s 1; SA CRA, *supra* note 747 at s 3; Qld CRA, *supra* note 747 at s 4; NT CRA, *supra* note 747 at s 3; WA CRA, *supra* note 747 at s 3; see also, Tas Carer Policy, *supra* note 748 at 7.

<sup>751</sup> Vic CRA, *ibid* at s 1; SA CRA, *ibid* at s 3; The Tasmanian Carer Policy also seeks to support policy (Tas Carer Policy, *ibid* at 7).

<sup>752</sup> NSW CRA, *supra* note 747 at s 4; SA CRA, *ibid* at s 5; Qld CRA, *supra* note 747 at s 6; NT CRA, *supra* note 747 at s 5; WA CRA, *supra* note 747 at s 5; Vic CRA, *ibid* at s 3, 4; see also Tas Carer Policy, *ibid* at 6-7.

<sup>753</sup> NSW CRA, *ibid* at s 9; Vic CRA, *ibid* at s 10; Qld CRA, *ibid* at s 8.

<sup>754</sup> NSW CRA, *ibid* at s 7; SA CRA, *supra* note 747 at s 6; Qld CRA, *ibid* at s 9; NT CRA, *supra* note 747 at s 6; WA CRA, *supra* note 747 at s 6. The Victoria CRA requires that organisations understand the principles in the act, and consider the views of carers but does not directly require consultation (*ibid* at s 7, 8, 9, 11). Tasmanian Carer Policy also reflects these requirements (*supra* note 748 at 8, 9).

<sup>755</sup> NSW CRA, *ibid* at s 8; Vic CRA, *supra* note 747 at s 12; SA CRA, *ibid* at s 7; Qld CRA, *ibid* at s 10; NT CRA, *ibid* at s 7; WA CRA, *ibid* at s 7; see also Tas Carer Policy, *ibid* at 11.

<sup>756</sup> NSW CRA, *ibid* at s 10, 11, 12; Qld CRA, *ibid* at s 11, 12, 14; WA CRA, *ibid* at s 8, 9.

<sup>757</sup> NSW CRA, *ibid* at Sch 1; Vic CRA, *supra* note 747 at s 7, 8, 9; SA CRA, *supra* note 747 at Sch 1; Qld CRA, *ibid* at Sch; NT CRA, *supra* note 747 at Sch; WA CRA, *ibid* at Sch 1; see also Tas Carer policy, *supra* note 748 at 8-9.



Commonwealth government main website provides links to many resources for carers.<sup>758</sup> The DHS website details information on what payments are available to carers, how to apply for carer payments, and how to choose the best pension option.<sup>759</sup>

There are several health-related government websites which give information to carers. The Health Direct website provides information to carers on how to care, and links to counselling and support group options and aged care services.<sup>760</sup> The Department of Health website has a section on ageing and aged care.<sup>761</sup> The My Aged Care website, along with having detailed information on eligibility and accessing home care for seniors, also has information on carer supports, and tips on how to care for seniors with specific health conditions.<sup>762</sup>

The Carer Gateway is a dedicated website providing information and resources to carers.<sup>763</sup> The website and its related phone information service are funded by the Australian government.<sup>764</sup> Factual information includes information on what health care services are available to aid care recipients, how to receive financial support, how to receive respite care, and medical condition information.<sup>765</sup> Additionally, the website gives advice to carers on taking care of their health and how to balance care work and paid work.<sup>766</sup> The Carer Gateway gives advice to carers whose caring responsibilities have changed or ended.<sup>767</sup> The website has sections for specific subgroups of carers, such as young carers, indigenous carers, and rural carers.<sup>768</sup>

### **Respite Care**

Carers have access to several different types of respite care through the health care system.<sup>769</sup> Respite services are provided with the intention of allowing carers to continue their role for a longer period of time.<sup>770</sup> The ACA defines respite as "...residential care or flexible

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<sup>758</sup> Australian Government, "Carers", online: <[www.australia.gov.au/information-and-services/benefits-and-payments/carers](http://www.australia.gov.au/information-and-services/benefits-and-payments/carers)> [Australian Carers Information Website].

<sup>759</sup> Australian Government, Department of Human Services, "Carers", online: <[www.humanservices.gov.au/customer/themes/carers](http://www.humanservices.gov.au/customer/themes/carers)> [Carer Payments Website].

<sup>760</sup> Health Direct, "Caring for Others", online: <[www.healthdirect.gov.au/caring-for-others](http://www.healthdirect.gov.au/caring-for-others)> [Health Direct Website].

<sup>761</sup> Australian Government, Department of Health "Ageing and Aged Care", online: <[agedcare.health.gov.au/](http://agedcare.health.gov.au/)> [Department of Health Website].

<sup>762</sup> My Aged Care Website, *supra* note 159.

<sup>763</sup> Carer Gateway Website, *supra* note 722.

<sup>764</sup> Carer Gateway Website, *ibid.*

<sup>765</sup> Carer Gateway Website, *ibid.*

<sup>766</sup> Carer Gateway Website, *ibid.*

<sup>767</sup> Carer Gateway Website, *ibid.*

<sup>768</sup> Carer Gateway Website, *ibid.*

<sup>769</sup> My Aged Care Website, *supra* note 159 at Caring for Someone; Carer Gateway Website, *ibid.*

<sup>770</sup> My Aged Care Website, *ibid.*

care (as the case requires) provided as an alternative care arrangement with the primary purpose of giving a carer or a care recipient a short-term break from their usual care arrangement...<sup>771</sup> What types of respite care are available depend on where a carer and care recipient are living, and what their circumstances are.<sup>772</sup> For respite provided directly through the government, carers can request respite through the aged care system, or through a government respite centre.<sup>773</sup> There are some government subsidies to help cover the cost of respite care, although a contribution is expected from the care recipient.<sup>774</sup>

There are two types of respite available – community or residential respite. For community-based respite, respite can take place in the home of the carer or recipient for one day or night.<sup>775</sup> Community respite can also take place outside of the home, such as at a day centre where there are activities provided for the care recipient, or at a community access respite centre where the care recipient can engage in social activities.<sup>776</sup> In contrast, residential respite can be provided for multiple days or nights.<sup>777</sup> Care recipients who require a high level of care may be able to access respite care in an aged care home.<sup>778</sup> Respite care can also be provided on an emergency basis to deal with an unexpected situation, such as the carer becoming ill.<sup>779</sup>

To receive residential respite care, care recipients must be assessed by the Aged Care Assessment Team.<sup>780</sup> Care recipients will be determined to require a high or low level of care, and the assessment team will determine what respite care they are eligible for.<sup>781</sup> For residential respite care, care recipients must pay a daily fee, which is a maximum of A\$49.42 per day, and may be asked for a pre-payment to book the spot.<sup>782</sup> Residential respite care is available for up

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<sup>771</sup> ACA, *supra* note 160 at Schedule 1, cl 1. Flexible care is defined in section 49-3 as "...care provided in a residential or community setting through an \*aged care service that addresses the needs of care recipients in alternative ways to the care provided through residential care services and home care services."

<sup>772</sup> My Aged Care Website, *supra* note 159 at Caring for Someone; Health Direct Website, *supra* note 760; Carer Gateway Website, *supra* note 722.

<sup>773</sup> Health Direct Website, *ibid*; Carer Gateway Website, *ibid*.

<sup>774</sup> My Aged Care Website, *supra* note 159 at Caring for Someone; ACA, *supra* note 160 at s 44-5. The residential respite subsidy ranges from A\$45.45 to A\$127.46 depending on level of care assessment: DOH, Aged Care Subsidies, *supra* note 699 at 2.

<sup>775</sup> My Aged Care Website, *ibid*; Health Direct Website, *supra* note 760; Carer Gateway Website, *supra* note 722.

<sup>776</sup> My Aged Care Website, *ibid*; Health Direct Website, *ibid*; Carer Gateway Website, *ibid*.

<sup>777</sup> My Aged Care Website, *ibid*; Carer Gateway Website, *ibid*.

<sup>778</sup> My Aged Care Website, *ibid*; Health Direct Website, *supra* note 760; Carer Gateway Website, *ibid*.

<sup>779</sup> Health Direct Website, *ibid*; Carer Gateway Website, *ibid*.

<sup>780</sup> My Aged Care Website, *supra* note 159 at Caring for Someone; Carer Gateway Website, *ibid*.

<sup>781</sup> My Aged Care Website, *ibid*; Carer Gateway Website, *ibid*; *Classification Principles 2014* (Cth), at s 7, 11(2); *ACRP*, *supra* note 160 at s 10; ACA, *supra* note 160 at s 25-2, 25-3.

<sup>782</sup> My Aged Care Website, *ibid*; ACA, *ibid* at s 44-3(3)(b), 52G-2(b); 52G-6(b); *Fees and Payments Principles 2014* (No 2) (Cth) at s 10.

to 63 days per year, although this can be extended another 21 days if assessed as needing this.<sup>783</sup>

While research in this area is mixed, respite care may in practice not be sufficient to help the needs of carers. Health Direct notes to carers that government-provided respite services are limited, so clients are often placed on waitlists until services become available.<sup>784</sup> Stockwell-Smith et al. found that carers are not using respite services as much as expected and that the available respite is not being fully used up, ranging from 20 to 67% usage.<sup>785</sup> The authors argued that reasons for a lack of use may be staff turnover in respite care, the care recipient not liking the respite care, carers not knowing how to access respite care, and carers using informal sources of respite instead of the formal system.<sup>786</sup> However, other research suggests that carers are not receiving as much respite care services as they need.<sup>787</sup> O'Connell et al. in a self-report survey found that half of carers desired more hours of respite than they were given, although the usage rates differed widely from a few times a year to weekly.<sup>788</sup> They also found that respite use was increasing each year.<sup>789</sup>

### Payments to Carers

Carers in Australia may be eligible for payments from the government to support them in providing care work.<sup>790</sup> The three payments applicable to carers of the elderly are the Carer Allowance, the Carer Payment, and the Carer Supplement.<sup>791</sup> These payments are typically for carers who are caring full-time and thus not likely to be able to be employed full time, and may have additional costs due to their caring responsibilities.<sup>792</sup>

The Carer Allowance is an income supplement for carers who are providing a significant amount of informal care work.<sup>793</sup> Carers must be providing care every day to a family member, and be living in Australia.<sup>794</sup> The care recipient must live in Australia, have a medical condition,

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<sup>783</sup> My Aged Care Website, *ibid*.

<sup>784</sup> Health Direct Website, *supra* note 760.

<sup>785</sup> Stockwell-Smith et al., *supra* note 183 at 2058.

<sup>786</sup> Stockwell-Smith et al., *ibid* at 2060-2062.

<sup>787</sup> O'Connell et al., *supra* note 194 at 111-112, 114.

<sup>788</sup> O'Connell et al., *ibid* at 114.

<sup>789</sup> O'Connell et al., *ibid* at 111.

<sup>790</sup> Carer Payments Website, *supra* note 759.

<sup>791</sup> Carer Payments Website, *ibid*.

<sup>792</sup> Carer Payments Website, *ibid*.

<sup>793</sup> Carer Payments Website, *ibid*. To qualify, if the care receiver and carer live in the same home the recipient must "receive[] care and attention on a daily basis" (*Social Security Act 1991* (Cth) [SSA] s 954(1)(d)), or if they do not live in the same home, "...on a daily basis, for a total of at least 20 hours a week;..." (SSA s 954A(2)(b)).

<sup>794</sup> Carer Payments Website, *ibid*; SSA, *ibid* at s 954, 954A.

disability, or be a frail elderly individual, and must be assessed by a health professional.<sup>795</sup> The care work must take place in the home of the carer or care recipient.<sup>796</sup> There are no income and asset maximums for receiving the carer allowance, so the carer can be employed full-time and receive the carer allowance if they provide a sufficient amount of informal care work.<sup>797</sup> The carer allowance is A\$63.55 per week per care recipient, although this amount will be adjusted if the care recipient has more than one main carer.<sup>798</sup> The carer allowance is not taxable.<sup>799</sup>

The Carer Allowance payment can be backdated for up to 12 weeks if the caring responsibilities begin suddenly due to an illness or accident.<sup>800</sup> Carers can take up to 63 days per year off from caring and still receive the carer allowance.<sup>801</sup> The care recipient can spend up to 63 days in the hospital without the payment being impacted.<sup>802</sup>

The Carer Payment is for carers who are providing continuous care work for a recipient and, because of these care responsibilities, have limited participation in paid employment.<sup>803</sup> To be eligible for the carer payment, the carer must be providing constant care work for at least 6 months and be living in Australia.<sup>804</sup> The care does not have to be continuous if the carer is providing assistance for multiple recipients.<sup>805</sup> The care recipient must be living in Australia, have a disability or medical condition that leads to them requiring care, be assessed by a medical professional, and be experiencing the medical condition for at least 6 months (unless the recipient has a terminal illness).<sup>806</sup> Care work must be provided in the home of either the carer or recipient.<sup>807</sup> The rate for the carer payment, including supplements, is A\$894.40 per two

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<sup>795</sup> Carer Payments Website, *ibid*; SSA, *ibid* at s 954, 954A. The severity of the disability or medical condition is “...assessed and rated under the Adult Disability Assessment Tool and given a score under that assessment tool of at least 30...” (SSA, s 954A(1)(c)).

<sup>796</sup> Carer Payments Website, *ibid*; SSA, *ibid* at s 954, 954A.

<sup>797</sup> Carer Payments Website, *ibid*.

<sup>798</sup> Carer Payments Website, *ibid*; SSA, *supra* note 793 at s 974, 981.

<sup>799</sup> Carer Payments Website, *ibid*.

<sup>800</sup> Carer Payments Website, *ibid*.

<sup>801</sup> Carer Payments Website, *ibid*; SSA, *supra* note 793 at s 957.

<sup>802</sup> Carer Payments Website, *ibid*; SSA, *ibid* at s 955, 957.

<sup>803</sup> Carer Payments Website, *ibid*; SSA, *ibid* at s 197D, 198. ‘Continuous care’ is not defined in the SSA or on the Carer Payments Website. The Carer Payments Website, *ibid*, does describe that you need to provide “...constant, daily care...” and that you cannot “... spend [...] more than 25 hours a week away from caring for work, study or training”, which together would suggest the care must be at least every day and take up a significant amount of time such that full time work or school could not be achieved.

<sup>804</sup> Carer Payments Website, *ibid*; SSA, *ibid* at s 197D, 198.

<sup>805</sup> SSA, *ibid* at s 197(7).

<sup>806</sup> Carer Payments Website, *supra* note 759; SSA, *ibid* at s 197D, 198.

<sup>807</sup> Carer Payments Website, *ibid*; SSA, *ibid* at s 197D, 198.

weeks for a single person and A\$1348.40 per two weeks for a couple.<sup>808</sup>

Both the carer and care recipient must meet an income and asset test to qualify for the Carer Payment.<sup>809</sup> The care recipient must have an income at or below A\$112,006 and assets valued at or below A\$691,000 or be receiving a government pension or benefit.<sup>810</sup> The carer must have assets below A\$253,750 for a single individual or below A\$380,500 in combined assets for a couple.<sup>811</sup> Carers must report their income and their spouse's income.<sup>812</sup>

While the carer is receiving the Carer Payment, they cannot engage in paid work or study for more than 25 hours per week, which includes the time to get to and from paid work or school.<sup>813</sup> Any income the carer earns will reduce the amount of carer payment they receive.<sup>814</sup> The carer can take up to 63 days per year away from caring without the carer payment stopping.<sup>815</sup> The payment will continue for up to 63 days while the care recipient is temporarily in the hospital.<sup>816</sup> If the care recipient enters residential care permanently, the carer can receive the payment for up to 14 weeks after the entry date.<sup>817</sup>

The Carer Supplement is intended to help carers who are already receiving a government payment with costs of care work that they personally incur.<sup>818</sup> The Carer Supplement is paid to those who receive a Carer Allowance, Carer Payment, or several other government allowances or pensions.<sup>819</sup> Carer Supplements are automatically paid to carers once per year.<sup>820</sup> The payment is A\$600 per year if caring full time, or a portion if the care recipient has multiple carers.<sup>821</sup>

Once a carer has reached the age of 65, they can choose whether they wish to continue receiving the Carer Payment or if they wish to receive the Age Pension instead.<sup>822</sup> To qualify, the carer would also have to be living in Australia, have been a resident Australia for at least 10

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<sup>808</sup> Carer Payments Website, *ibid*; SSA, *ibid* at s 210.

<sup>809</sup> Carer Payments Website, *ibid*; SSA, *ibid* at s 197D, 198, 198A.

<sup>810</sup> Carer Payments Website, *ibid*; SSA, *ibid* at s 198B, 198D.

<sup>811</sup> Carer Payments Website, *ibid*; SSA, *ibid* at s 198D.

<sup>812</sup> Carer Payments Website, *ibid*.

<sup>813</sup> Carer Payments Website, *ibid*.

<sup>814</sup> Carer Payments Website, *ibid*.

<sup>815</sup> Carer Payments Website, *ibid*; SSA, *supra* note 793 at s 198AC.

<sup>816</sup> Carer Payments Website, *ibid*; SSA, *ibid* at s 198AA, 198AC.

<sup>817</sup> SSA, *ibid* at s 198AAA.

<sup>818</sup> Carer Payments Website, *supra* note 759; SSA, *ibid* at s 992X(1).

<sup>819</sup> Carer Payments Website, *ibid*; SSA, *ibid* at s 992X(1).

<sup>820</sup> Carer Payments Website, *ibid*.

<sup>821</sup> Carer Payments Website, *ibid*; SSA, *supra* note 793 at s 992X(2).

<sup>822</sup> Carer Payments Website, *ibid*; SSA, *ibid* at s 43.

years, and be living in Australia the two years prior to claiming the age pension.<sup>823</sup> There are also income and asset tests for the age pension; the pensioner must have an income of less than A\$168 every two weeks for a single pensioner or A\$300 as a couple to not have a reduced pension amount.<sup>824</sup> The pension rate would be zero if the income reaches A\$1956.80 every two weeks for a single person or A\$2996.80 for a couple.<sup>825</sup> The age pension rate for those living within Australia is A\$894.40 per two weeks for a single pension recipient, or A\$1348.40 combined for a couple.<sup>826</sup>

Carers who would qualify for both the Age Pension or Carer Payment can choose whichever they would find better.<sup>827</sup> There are some similarities between the two types of pensions – both have income and asset tests and both are taxable once the carer reaches 65 years of age.<sup>828</sup> However the carer payment does have greater eligibility criteria than the age pension.<sup>829</sup> For example, there is no asset test for the care receiver in the age pension, the age pension can be paid outside of Australia for a longer period of time, and there are no limits to the respite the carer can take per year.<sup>830</sup> However, the carer would no longer be eligible for the carer supplement if they transferred to the age pension.<sup>831</sup>

### **Employment Leaves**

Employed caregivers have access to a few types of leaves to help them balance paid work and care work – Sick and Carer’s Leave, Unpaid Carer’s Leave, and Compassionate Leave.<sup>832</sup> The Sick and Carer’s leave, also known as personal/carer leave, is a combined paid 10 days per year an employee can take off from paid work for either a personal illness or for caring responsibilities.<sup>833</sup> If the Sick and Carer’s Leave is being taken to care for a family member, the employee must be caring for a listed family member, including a spouse, parent, or grandparent, or other family living within the carer’s home.<sup>834</sup> Care recipients must be ill or experiencing an

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<sup>823</sup> Carer Payments Website, *ibid*; SSA, *ibid* at s 43.

<sup>824</sup> Carer Payments Website, *ibid*.

<sup>825</sup> Carer Payments Website, *ibid*.

<sup>826</sup> Carer Payments Website, *ibid*; SSA, *supra* note 793 at s 55.

<sup>827</sup> Carer Payments Website, *ibid*.

<sup>828</sup> Carer Payments Website, *ibid*.

<sup>829</sup> Carer Payments Website, *ibid*.

<sup>830</sup> Carer Payments Website, *ibid*.

<sup>831</sup> Carer Payments Website, *ibid*.

<sup>832</sup> Australian Government, Fair Work Ombudsman, “Leave”, online: <[www.fairwork.gov.au/leave/sick-and-carers-leave](http://www.fairwork.gov.au/leave/sick-and-carers-leave)> [Carer Leaves Website].

<sup>833</sup> Carer Leaves Website, *ibid*; Fair Work Act 2009 (Cth) [FWA] at s 96(1), 97.

<sup>834</sup> Carer Leaves Website, *ibid*.



emergency.<sup>835</sup> For the 10 days of leave per year, the employee must be paid at their ordinary wage.<sup>836</sup> Leave can be taken in any length of time, up to the maximum number of leave days accrued.<sup>837</sup>

The leave accrues for full-time employees over each year the employee works or is on paid leave, and accrues for part-time employees on a pro-rated basis calculated on the number of hours they are working.<sup>838</sup> At the end of the year, any unused leave days carry over into the next year.<sup>839</sup> In order to take leave, the employee must notify their employer as soon as possible, but this does not have to be prior to the leave due to the fact that this leave may be taken for an emergency.<sup>840</sup> The employer can ask for reasonable evidence on why the employee was taking leave; the employee contract or policy can specify what evidence the employee must provide.<sup>841</sup>

Full or part-time carers can take Unpaid Carer's Leave if they have used up their paid sick and carer's leave.<sup>842</sup> As well, this leave is available to casual employees.<sup>843</sup> Carers can take off two days for each time they have a family member who is ill, either as a single two day period or at two different times.<sup>844</sup> Unpaid carers leave protects employees from being penalized for taking leave.<sup>845</sup> Carers can take time off paid work to care for an immediate family member such as a parent, or any other relative living in their home.<sup>846</sup>

Any employed carer, including casual employees, can take paid Compassionate Leave for a family member who is at risk of dying.<sup>847</sup> The employee can take this leave to spend time with an immediate family member such as a spouse or parent, or any other family member who lives in the carer's home.<sup>848</sup> Carers can take this leave for other family members with the employer's permission.<sup>849</sup> The care recipient must have "...a life threatening illness or injury."<sup>850</sup> The carer

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<sup>835</sup> Carer Leaves Website, *ibid*; FWA, *supra* note 833 at s 97.

<sup>836</sup> Carer Leaves Website, *ibid*; FWA, *ibid* at s 99.

<sup>837</sup> Carer Leaves Website, *ibid*.

<sup>838</sup> Carer Leaves Website, *ibid*; FWA, *supra* note 833 at s 96(2).

<sup>839</sup> Carer Leaves Website, *ibid*.

<sup>840</sup> Carer Leaves Website, *ibid*; FWA, *supra* note 833 at s 107(1), (2).

<sup>841</sup> Carer Leaves Website, *ibid*; FWA, *ibid* at s 107(3).

<sup>842</sup> Carer Leaves Website, *ibid*; FWA, *ibid* at s 103(3).

<sup>843</sup> Carer Leaves Website, *ibid*.

<sup>844</sup> Carer Leaves Website, *ibid*; FWA, *supra* note 833 at s 102, 103(2).

<sup>845</sup> Carer Leaves Website, *ibid*; FWA, *ibid* at s 102, 103(1).

<sup>846</sup> Carer Leaves Website, *ibid* – this is the same list of eligible family members as the paid sick and carer's leave.

<sup>847</sup> Carer Leaves Website, *ibid*; FWA, *supra* note 833 at s 104, 105(1).

<sup>848</sup> Carer Leaves Website, *ibid*; FWA, *ibid* at s 104, 105(1).

<sup>849</sup> Carer Leaves Website, *ibid*.

<sup>850</sup> Carer Leaves Website, *ibid*.



can also take compassionate leave after a family member has died.<sup>851</sup> Leave can be taken for each time a family member is at risk of dying or has died.<sup>852</sup>

Full or part-time employees can take two days of paid leave at the rate of their normal wage.<sup>853</sup> Casual employees can also take two days of compassionate leave, but it is unpaid.<sup>854</sup> This leave can be taken as a continuous two days or in smaller increments if the employer agrees.<sup>855</sup> Compassionate Leave, like Unpaid Carer's Leave, does not carry over to the next year.<sup>856</sup> Carers must give their employee notice they are taking leave as soon as possible, but this can be after the leave has commenced.<sup>857</sup> Employers are entitled to ask for evidence for the leave, and the type of evidence required can be specified by the employment contract or workplace policies.<sup>858</sup> However the evidence must be reasonable, such as a death certificate.<sup>859</sup>

### **Flexible Working Arrangements**

Employed carers in Australia can request to have their work arrangements altered to better allow them to balance paid work and care work responsibilities.<sup>860</sup> Types of flexible work arrangements could include changing job hours or working from home.<sup>861</sup> Employees must be a parent or caring for someone with a disability.<sup>862</sup> The definition of a carer that is used for applying flexible work arrangements is the definition from the *CRA*.<sup>863</sup> Full or part-time employees must have worked for their employer for at least 12 months before they can request flexible work arrangements, and casual employees must have worked for a regular period of at least 12 months with their employer, or expect to continue working regularly for the same employer, before they can request flexible work arrangements.<sup>864</sup> The employee must request

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<sup>851</sup> Carer Leaves Website, *ibid*; *FWA*, *supra* note 833 at s 105(1)(b).

<sup>852</sup> Carer Leaves Website, *ibid*; *FWA*, *ibid* at s 104.

<sup>853</sup> Carer Leaves Website, *ibid*; *FWA*, *ibid* at s 105(2), 106.

<sup>854</sup> Carer Leaves Website, *ibid*.

<sup>855</sup> Carer Leaves Website, *ibid*; *FWA*, *supra* note 833 at s 105(2).

<sup>856</sup> Carer Leaves Website, *ibid*.

<sup>857</sup> Carer Leaves Website, *ibid*; *FWA*, *supra* note 833 at s 107(1), (2).

<sup>858</sup> Carer Leaves Website, *ibid*; *FWA*, *ibid* at s 107(3).

<sup>859</sup> Carer Leaves Website, *ibid*; *FWA*, *ibid* at s 107(3).

<sup>860</sup> Australian Government, Fair Work Ombudsman, "Request for flexible working arrangements", online: <[www.fairwork.gov.au/how-we-will-help/templates-and-guides/fact-sheets/minimum-workplace-entitlements/requests-for-flexible-working-arrangements](http://www.fairwork.gov.au/how-we-will-help/templates-and-guides/fact-sheets/minimum-workplace-entitlements/requests-for-flexible-working-arrangements)> [Flexible Work Arrangements Website]; *FWA*, *ibid* at s 65(1).

<sup>861</sup> Flexible Work Arrangements Website, *ibid*; *FWA*, *ibid* at s 65(1).

<sup>862</sup> Flexible Work Arrangements Website, *ibid*; *FWA*, *ibid* at s 65(1A).

<sup>863</sup> Flexible Work Arrangements Website, *ibid*; *Cth CRA*, *supra* note 724; *FWA*, *ibid* at s 65(1A). The *Carer Recognition Act 2010* defines who a carer is in section 5. See the Carer Recognition Section previously in this chapter for the definition.

<sup>864</sup> Flexible Work Arrangements Website, *ibid*; *FWA*, *ibid* at s 65(2).

these changes in writing, and the employer must give a written response within 21 days of the request.<sup>865</sup> Employers can refuse the request only for reasonable business grounds:

- (a) that the new working arrangements requested by the employee would be too costly for the employer;
- (b) that there is no capacity to change the working arrangements of other employees to accommodate the new working arrangements requested by the employee;
- (c) that it would be impractical to change the working arrangements of other employees, or recruit new employees, to accommodate the new working arrangements requested by the employee;
- (d) that the new working arrangements requested by the employee would be likely to result in a significant loss in efficiency or productivity;
- (e) that the new working arrangements requested by the employee would be likely to have a significant negative impact on customer service.<sup>866</sup>

The Fair Work Ombudsman encourages the employer and employee to negotiate a flexible work arrangement that would work for both.<sup>867</sup> However, if the employee believes the employer did not have reasonable business grounds to refuse the request, there are legal avenues to adjudicate the dispute such as the Fair Work Commission, or the employee can make a claim under a relevant discrimination statute.<sup>868</sup>

### **Tax Offsets**

Carers in Australia may be eligible for the Dependant (Invalid and Invalid Carer) tax offset.<sup>869</sup> The tax offset helps reduce any taxes which are owed, but if the tax payer does not have sufficient income to take advantage of the full tax offset amount, the unused offset amount cannot be paid to the carer; it remains unused.<sup>870</sup> To be eligible for the offset, the taxpayer must have: maintained a spouse, parent, or child of the taxpayer who received certain disability support pensions; or maintained a carer of a person with a disability who was receiving a carer allowance or carer payment; or maintained a carer of a spouse or sibling with a disability who provides full-time care to a child, or sibling who receive a disability payment.<sup>871</sup> The claimant (and their spouse, jointly) must have had an income of A\$100,000 or less, and the dependent or

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<sup>865</sup> Flexible Work Arrangements Website, *ibid*; FWA, *ibid* at s 65(3), (4).

<sup>866</sup> FWA, *ibid* at s 65 (5), (5A).

<sup>867</sup> Flexible Work Arrangements Website, *supra* note 860.

<sup>868</sup> Flexible Work Arrangements Website, *ibid*.

<sup>869</sup> Australian Government, Australian Taxation Office, "T6 Invalid and Invalid Carer 2016", online: <[www.ato.gov.au/Individuals/Tax-return/2016/Supplementary-tax-return/Tax-offset-questions-T3-T9/T6-Invalid-and-invalid-carer-2016/](http://www.ato.gov.au/Individuals/Tax-return/2016/Supplementary-tax-return/Tax-offset-questions-T3-T9/T6-Invalid-and-invalid-carer-2016/)> [Carer Tax Offset Website]; *Income Tax Assessment Act 1997* (Cth), s 61-5 [Cth ITAA].

<sup>870</sup> Carer Tax Offset Website, *ibid*.

<sup>871</sup> Carer Tax Offset Website, *ibid*; Cth ITAA, *supra* note 869 at s 61-10.

carer must have an income of less than A\$10,634.<sup>872</sup> The claimant would not be eligible for this tax offset if either they or their spouse received the family tax benefit.<sup>873</sup> This offset can be claimed only once per year and only one offset per couple.<sup>874</sup> The claimant is considered to have maintained a person if they resided in the same household, provided the care recipient with necessities, or helped pay for their living costs.<sup>875</sup>

### Community Caregiver Resources

In Australia, there is a nationwide organization called Carers Australia which represents carers, advocates on their behalf, and provides them with services to assist them in performing their caring role.<sup>876</sup> The goals of Carers Australia include advocating for government, health system, and community recognition and support of carers, and having carer associations across Australia to aid informal carers.<sup>877</sup> Carers, as defined by this organisation, “are people who provide unpaid care and support to family members and friends who have a disability, mental illness, chronic condition, terminal illness, an alcohol or other drug issue or who are frail aged.”<sup>878</sup> Carers Australia represents the needs of carers when the government is consulting with carers during policy development.<sup>879</sup> Additionally, the organization lobbies and advocates for carer services, including a wide range of carer supports such as those that would aid carer’s physical health or financial circumstances.<sup>880</sup>

Carers Australia has carer associations in each state or territory, which administer programs to carers and provide them with information and assistance.<sup>881</sup> For example, the Carers Australian Capital Territory (Carers ACT) association provides services such as counselling, support groups, and carer education workshops.<sup>882</sup> Carers ACT’s counselling services are provided by qualified counsellors to aid carers in managing stress and aspects of their caring

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<sup>872</sup> Carer Tax Offset Website, *ibid*; Cth ITAA, *ibid* at s 61-20.

<sup>873</sup> Carer Tax Offset Website, *ibid*.

<sup>874</sup> Carer Tax Offset Website, *ibid*.

<sup>875</sup> Carer Tax Offset Website, *ibid*.

<sup>876</sup> Carers Australia, “About Us”, “How we Work”, “About Carers”, online: <[www.carersaustralia.com.au/home/](http://www.carersaustralia.com.au/home/)> [Carers Australia Website].

<sup>877</sup> Carers Australia Website, *ibid*.

<sup>878</sup> Carers Australia Website, *ibid*.

<sup>879</sup> Carers Australia Website, *ibid*.

<sup>880</sup> Carers Australia Website, *ibid*.

<sup>881</sup> Carers Australia Website, *ibid*.

<sup>882</sup> Carers Australian Capital Territory, “How can we help?” online: <[www.carersact.org.au/](http://www.carersact.org.au/)> [Carers ACT Website].

role.<sup>883</sup> Counselling services are funded through the Commonwealth and the State government.<sup>884</sup> Support groups are organized monthly for carers to meet other carers and help each other.<sup>885</sup> Monthly workshops are provided free to carers by experts in the field to give them skills and information on a wide range of topics, including dealing with emotional impacts of caring and skills to care for recipients with specific medical conditions.<sup>886</sup> Carers ACT provides respite care and organises community services such as meal delivery and day programs.<sup>887</sup> For carers who are in the workforce or trying to re-enter the workforce, staff can help carers speak to their employers about obtaining flexible work practices.<sup>888</sup> Carers ACT also runs a centre which provides information to carers, and helps carers or recipients obtain health services, community services, and respite care.<sup>889</sup> The website also provides carers with information about caring, advice on how to take care of oneself, and how to advocate for their and the care recipients' needs.<sup>890</sup> Carer associations in Victoria, New South Wales, Queensland, South Australia, Tasmania, Western Australia, and the Northern Territory also provide similar programs.<sup>891</sup>

### Conclusion

This chapter has examined home care and carer supports in Australia. Home care includes personal care and transition care.<sup>892</sup> Australia has many carer supports, including carer recognition legislation, government provided information, and respite.<sup>893</sup> Financial and employment supports include payments for care work, tax offsets, employment leaves, and the ability to request flexible work arrangements.<sup>894</sup> Carer organizations help carers support one another.<sup>895</sup> These supports are compared to the Canadian supports in the next chapter.

<sup>883</sup> Carers ACT Website, *ibid*.

<sup>884</sup> Carers ACT Website, *ibid*.

<sup>885</sup> Carers ACT Website, *ibid*.

<sup>886</sup> Carers ACT Website, *ibid*.

<sup>887</sup> Carers ACT Website, *ibid*.

<sup>888</sup> Carers ACT Website, *ibid*.

<sup>889</sup> Carers ACT Website, *ibid*.

<sup>890</sup> Carers ACT Website, *ibid*.

<sup>891</sup> Carers Victoria, "How can we help?" online: <[www.carersvictoria.org.au/](http://www.carersvictoria.org.au/)>; Carers New South Wales, "How can we help?" online: <[www.carersnsw.org.au/](http://www.carersnsw.org.au/)>; Carers Queensland Website, <[carersqld.asn.au/](http://carersqld.asn.au/)>; Carers South Australia Website, <[carers-sa.asn.au/](http://carers-sa.asn.au/)>; Carers Tasmania, <[www.carerstas.org/](http://www.carerstas.org/)>; Carers Western Australia, <[www.carerswa.asn.au/](http://www.carerswa.asn.au/)>; Carers Northern Territory, <[www.carersnt.asn.au/](http://www.carersnt.asn.au/)>.

<sup>892</sup> My Aged Care Website, *supra* note 159.

<sup>893</sup> Cth CRA, *supra* note 724; Carer Gateway Website, *supra* note 722; Health Direct Website, *supra* note 760; Carer Payments Website, *supra* note 758; My Aged Care Website, *ibid*; ACA, *supra* note 159.

<sup>894</sup> Carer Payments Website, *ibid*; Carer Leaves Website, *supra* note 832; FWA, *supra* note 833; Flexible Work Arrangements Website, *supra* note 860; Carer Tax Offset Website, *supra* note 869.

<sup>895</sup> Carers Australia Website, *supra* note 876; Carers ACT Website, *supra* note 882.

## **CHAPTER SIX: EVALUATIONS OF CAREGIVER SUPPORTS AND RELATIONAL ANALYSIS**

This chapter compares and evaluates the supports available to caregivers in both Canada and Australia to examine where the countries differ. This analysis includes legal and social science analyses of these supports and programs. I then discuss through the lens of relational autonomy the degree to which the support programs in both countries enhance or reduce the ability of the caregiver to make autonomous choices in whether and how she performs care work. This analysis includes examining how the legislation and policy in both countries structure and regulate informal care work and thus how the government regulates care work within the home, and the gendering of unpaid work.

This chapter analyzes the types of supports individually, comparing what is done in each country. This is because each type of support in Australia may have some benefits which could be of use to Canada, but there are also areas where the Australian supports are deficient in supporting caregivers and addressing the impacts on them. Most of the supports I examine may have some benefits, but are also insufficient in their current form to help Canadians, especially women. This analysis informs suggestions for how Australia's caregiver supports, while numerous in number compared to Canada and possessing some promising starting points, can still be augmented or changed to hopefully make reforms more successful.

### **Home and Community Care and Informal Care Work**

Home and community care is structured fairly similarly in both Canada and Australia, and informal care work in both countries plays the important role of providing care to the elderly where the formal health care system does not. Women in both countries are not given significant choice in filling the gaps left by the formal health care system to ensure their relatives or friends receive the care they need.

The overall structure of home care in BC and Ontario, as well as Australia is very similar. The Canadian provinces and Australian states have home care which offers services such as nursing care, other health care services, home support, and respite, although BC does not provide

home cleaning, which Ontario and Australia do.<sup>896</sup> I discuss below the reality of the lack of availability of these home care services to seniors. A significant difference in the home care programs is that in BC and Australia clients pay a subsidized fee for services, while in Ontario home care services are provided free to eligible clients.<sup>897</sup> Both countries also provide residential services for those seniors who cannot live independently in their own home.<sup>898</sup>

The home care system in both countries does leave a lot of care to be performed by informal caregivers, demonstrated by the fact that the BC policy states outright that formal care is meant to supplement informal and community care.<sup>899</sup> Less than 4% of the senior population receives formal care, leaving a significant amount of care work to family and friends. With BC formal care being designed to require informal care work to fulfill most of a senior's care, this puts significant pressure on women to care for their relatives and friends, but without recognition and compensation for this work. Women are not given significant choice in whether they engage in informal care work, and are not trained in providing this care work. Spencer and Soden argue that formal care in actuality is reserved for those who do not have family available to care for them, and informal care work, representing 80% of care for seniors, impacts female caregivers significantly, the impacts of which are ignored.<sup>900</sup>

In BC, when there are not enough available public services for clients who are requesting and approved for service, care is allocated on an urgency basis; the urgency criteria includes whether friends or family are providing care.<sup>901</sup> Ontario similarly makes one of their requirements for long-term care home entry that the individual does not have enough informal care to aid them.<sup>902</sup> While I do not argue against a criterion of urgency, which allows those most in need of care from a medical perspective to get it first, I argue that having informal care as a criterion for assessing urgency is problematic for caregivers. Caregivers may start helping their

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<sup>896</sup> BC H&CC Website, *supra* note 436; Best of Care, *supra* note 16 at 32; Ont H&CC Website, *supra* note 20; CCAC Policy Manual, *supra* note 479 at Ch 1; My Aged Care Website, *supra* note 159.

<sup>897</sup> BC H&CC Website, *ibid*; My Aged Care Website, *ibid*; ACA, *supra* note 160 at S 52D-1, 52D-2, 52D-3; DSS, 5 Steps to HCP, *supra* note 687; MOHLTC CCAC Website, *supra* note 480.

<sup>898</sup> Best of Care, *supra* note 16; My Aged Care Website, *ibid*; ACA, *ibid* at S 21-2; ACRP, *supra* note 160 at s 6; BC H&CC Policy Manual, *supra* note 16 at 5.B.

<sup>899</sup> BC H&CC Website, *supra* note 436.

<sup>900</sup> Charmaine Spencer & Ann Soden, "A Softly Greying Nation: Law, Ageing and Policy in Canada" (2007) 2 J Int'l Aging L & Policy 1 at 23-24.

<sup>901</sup> BC H&CC Policy Manual, *supra* note 16 at 2.C 1 of 1; BC H&CC Website, *supra* note 436; Best of Care, *supra* note 16 at 16.

<sup>902</sup> Seniors' Secretariat Guide, *supra* note 21; CCAC Policy Manual, *supra* note 479, ch 1 at 7; O Reg 79/10 s 115(d).



family or friends when care needs are lighter or after an inciting health event, and continue to care while the recipient's care needs increase. When care work becomes too great for caregivers, the time they have taken to care will be expected to continue, and will prevent the caregiver from accessing formal care to lessen their burden. The formal health care system policy may create a negative cycle where caregivers take up the care work when the need is urgent but they may not be able to stop this care work due to the care recipient being assessed as less in need because of their informal care work.

BC's Home and Community Care Policy Manual states that the program should be sustainable for both clients and caregivers.<sup>903</sup> The main focus of the policy manual and the program is services for care recipients without informal caregiving, and there is very little in the home care program directly addressing the unpaid caregiver. This will not ensure that the health care system is sustainable for caregivers, or for care recipients, if their main informal caregiver is not able to continue caring for them in the long-term. Lilly et al. in a qualitative study found caregivers reported needing more in-home care services as there was very little available and the lack of services impacted their health and ability to care.<sup>904</sup> Given research has established that care work has significant burdens and economic consequences for caregivers into retirement age,<sup>905</sup> the current formal health care system is not adequately ensuring the long-term sustainability of either the formal health care system or informal care work. Caregivers may not be able to perform as much care work if they are experiencing physical or emotional burdens or are not able to obtain sufficient income to support themselves while caring. Investing in the health and well-being of the caregiver may help increase the sustainability of the formal system by ensuring informal caregivers are able to continue this care role in the long-term, especially if the formal care system continues to expect informal care to predominate.

Ontario's provision of referrals for community services<sup>906</sup> is a useful program because it is an avenue for caregivers to obtain what could be hard-to-find health services for both the care recipient and themselves. Given that caregivers may play the role of care coordinator,<sup>907</sup> this service would help caregivers more easily find alternate services if they can afford to pay for them, as well as potentially finding supports for the caregiver themselves. However, care

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<sup>903</sup> BC H&CC Policy Manual, *supra* note 16 at 1A 2 of 4.

<sup>904</sup> Lilly et al., *supra* note 540 at 107.

<sup>905</sup> Lee, *supra* note 7 at 30-32; Williams, *supra* note 14 at 7-8; BCLI, *supra* note 3 at 1, 13, 24.

<sup>906</sup> CCAC Policy Manual, *supra* note 479 at Ch 5; MOHLTC CCAC Website, *supra* note 480.

<sup>907</sup> Pyper, *supra* note 10 at 5; Lafreniere et al., *supra* note 10 at 32-33; McMaster Citizen Brief, *supra* note 10 at 4.



recipients would have to be applying for home care to receive this service, so this information will only be useful for a subset of caregivers and care recipients.

The ACA governing home care in Australia specifically has the objective of ensuring respite care,<sup>908</sup> which does demonstrate a concern for ensuring caregivers do have some support. Australia's specific service of transitional care after a hospital stay<sup>909</sup> is a useful addition to the formal health care system for both caregivers and care recipients. The period after a hospital stay may be a period of increased care needs, so transitional care could help caregivers get additional formal care services when their need is highest, and if the care recipient's needs lessen after they recover, the caregiver can go back to performing the majority of the care work.

The general way that elder care is arranged in Canada gives women little autonomy from a relational perspective. Sherwin has argued that women providing informal care work are not in a situation to express full autonomy because they are oppressed; this oppression comes from the fact that society structures caregiving as a woman's role.<sup>910</sup> Nedelsky argues that dependency, and those who care for dependant individuals such as the elderly, are not valued by society.<sup>911</sup> Oppression prevents women from having choices available that fit their values.<sup>912</sup> Several authors argue that oppressed groups can come to internalize the choices that society wants them to make.<sup>913</sup> Women are socialized to care for family members.<sup>914</sup> The fact that there is not sufficient government-provided home care for the elderly leaves family to fulfil these care needs, unless they can be paid for privately. Society reinforces women performing this caregiving through socialization and the structure of health care and other laws. Women may also feel that they want or need to perform this care work. Caregivers may want to be able to maintain other activities and interests outside of the home such as full-time paid work, but these values and desires may come second to pressure to care for their relatives.

In addition to the health care system leaving a care gap for family to fulfill, women may also face relational and emotional pressures to care, which limit their options. Relational autonomy posits that relationships are important in determining a person's ability to act

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<sup>908</sup> ACA, *supra* note 160 at s 2-1; DSS, Guide to Aged Care Law, *supra* note 670.

<sup>909</sup> ACA, *ibid* at s 21-4, 49-3; ACRP, *supra* note 160 at s 8; My Aged Care Website, *supra* note 159.

<sup>910</sup> Sherwin, *supra* note 333 at 17.

<sup>911</sup> Nedelsky, *supra* note 317 at 27-29.

<sup>912</sup> Sherwin, *supra* note 333 at 19.

<sup>913</sup> Stoljar, *supra* note 383 at 379; Sherwin & Winsby, *supra* note 18 at 185.

<sup>914</sup> Brewer, *supra* note 105 at 220; Morris, *supra* note 68 at 106.

autonomously and influence who someone is.<sup>915</sup> Individuals do not make decisions purely on logic – emotion and relationships are an important and valuable aspect of decision-making.<sup>916</sup> Pressures on decisions can come from internalized values and beliefs as well as from external pressures such as other people and the structuring of state regulation.<sup>917</sup> Women are often faced with needing to care for relatives such as parents or spouses. Under this reality, women may feel pressure from society to care for relatives as well as emotional attachments to close family members who may be left without necessary care if caregivers do not step back from paid employment to provide more care work. The fact that these relationships exist and may influence a woman’s decisions is not necessarily problematic under relational autonomy. This emotional attachment to the care recipient will not go away. However, what can change is the way care work is organized for the elderly, how society divides care work and paid work, and legal recognition of dependency and the value of care work.

Relational autonomy theorists argue that state action is important in how much autonomy a person has.<sup>918</sup> While individual relationships can be good or bad for a person’s autonomy,<sup>919</sup> the health of the individual relationship in determining autonomy is not something the law can easily examine. However, the law can be changed to give women more options for balancing paid work and care work, restructure the gendering of care work to give women more options in whether they care for their elderly family members, and influence how much this care work takes away from other values such as engaging in paid work. If a woman wants to take time away from paid employment and other personal engagements, she has the autonomy to make this decision, and she is free from oppression, she should be able to make this choice. However, the law and health care system should be arranged such that women are not essentially forced to “choose” to perform this care work to their own detriment. Women’s autonomy will be increased if women are not faced with the choice of caring for a close family member or leaving the family member without any care, such as removing the requirement that family perform unpaid care work before any formal help can be obtained. The health care system and government’s reliance on family care as a determinant of formal care puts increased pressure on women who are already performing care work, because they may not be able to stop once they

<sup>915</sup> Nedelsky, *supra* note 317 at 118-119, 45-46; Kaposy & Downie, *supra* note 336 at 100.

<sup>916</sup> Downie & Llewellyn, *supra* note 338 at 200-202; Sherwin & Winsby, *supra* note 18 at 184.

<sup>917</sup> Downie & Llewellyn, *ibid* at 203-204; Nedelsky, *supra* note 317 at 127-132.

<sup>918</sup> Nedelsky, *ibid* at 131-132.

<sup>919</sup> Nedelsky, *ibid* at 118-119.

have started performing this unpaid care work. Women's autonomy is harmed when women are forced to continue performing care work because informal care work is a factor which decreases the eligibility for formal care. Policies like this reduce a woman's autonomy. The specific caregiver supports will be examined below to analyze how much they reduce or enhance a woman's autonomy in her decisions in caregiving and other aspects of her life.

### **Respite Care**

In BC, respite care is accessed through a care recipient who applies through the home and community care program and meets the general eligibility criteria for home care services.<sup>920</sup> Given the small percentage of BC seniors who receive home care,<sup>921</sup> this means that government-provided respite care would be very limited for informal caregivers just by the first hurdle of having a care recipient with formal care. Caregivers would then have to meet the criteria of needing a respite break and be able to afford the client rate.<sup>922</sup> This means that respite care through the government is very limited. There is very little information available on the province's websites about eligibility and the process of receiving respite care,<sup>923</sup> so more clarity is needed on what is available and how to access it.

Ontario does offer eligible clients free in-home respite care<sup>924</sup> which would make this service useable by caregivers and care recipients in all financial situations, but would be most helpful for those caregivers who are low income and cannot afford to purchase care services. Ontario also provides more information to caregivers on what types of respite care are available and how to receive them, which gives more clarity to caregivers,<sup>925</sup> even if access to services is very similar to BC and overall is insufficient.<sup>926</sup> The number of days available for respite care in long-term care, 90 days per year,<sup>927</sup> would give caregivers a fair amount of time for vacation, health care needs, time off to take care of themselves, or to have more time for paid employment on a longer time scale than in-home respite. The subsidized rates for long-term respite care for

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<sup>920</sup> BC H&CC Policy Manual, *supra* note 16 at 7.C.1 1 of 1; BC H&CC Website, *supra* note 436.

<sup>921</sup> Best of Care, *supra* note 16 at 9-10, 12, 32.

<sup>922</sup> BC H&CC Policy Manual, *supra* note 16 at 7.C.1 1 of 1; BC H&CC Website, *supra* note 436.

<sup>923</sup> BC H&CC Website, *ibid*.

<sup>924</sup> Ont Respite Care Website, *supra* note 565; To receive respite, care recipients apply through the CCAC, and the specific eligibility criteria depends on the type of respite and the specific program – for stays in long-term care facility the care recipient must need continuous care, and day programs depends on the specific day program in the area (Ont Respite Care Website).

<sup>925</sup> Ont Respite Care Website, *ibid* – respite care options include in-home respite care, a short stay in a long-term care facility, or adult day programs.

<sup>926</sup> Bringing Care Home, *supra* note 514 at 20.

<sup>927</sup> Ont Respite Care Website, *supra* note 565.

both BC and Ontario are fairly low, at \$33 per day and \$36.34 per day given that respite in a long-term care facility allows for continuous care.<sup>928</sup> Despite the positive aspects of the respite system in Ontario, the amount of services provided are not enough to meet clients' needs.<sup>929</sup>

Australia's respite care program is similar to what is offered in Canada, and does not seem to meet the needs of caregivers sufficiently either. Australia's respite care programs do offer a variety of types of respite care, such as in-home care, day centres for social activities, and residential respite care for longer-term care.<sup>930</sup> Having a wide variety of respite options could be helpful for both caregivers and care recipients – caregivers could have the amount of respite time they need, from a few hours to many days; care recipients could have programs that fulfill what they need, such as higher levels of care or interactions with other seniors. The number of days and fees are comparable to Canada, with up to 84 days for residential respite care with a fee of A\$49.42 per day.<sup>931</sup> However, research in Australia shows that the respite care actually available is not sufficient for caregivers. O'Connell et al. found that use of respite care varied quite widely in surveyed caregivers – most used at least two different types of respite care, and amounts of respite varied significantly from a couple hours a week to 50 hours per week.<sup>932</sup> However half of caregivers surveyed felt they did not receive sufficient respite care, and past studies have found that caregivers were not aware of available respite.<sup>933</sup> However, respite has been shown in studies to help both caregivers and care recipients – caregivers were able to have more time to attend to their own daily tasks and reduce psychological and physiological impacts, while care recipients were able to engage in social activities with others and receive therapies to improve functioning.<sup>934</sup> Respite care should not be overlooked by the formal health care system. There are benefits to both the caregiver and care receiver from a physical and psychological standpoint. Formal respite care is not sufficient in either country to support caregivers.

Respite time is important from a relational perspective for two reasons – to promote independence and to promote a healthy relationship between the caregiver and care recipient.

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<sup>928</sup> Ont Respite Care Website, *ibid*; BC H&CC Policy Manual, *supra* note 16 at 7.C.1 at 1 of 1.

<sup>929</sup> Bringing Care Home, *supra* note 514 at 20; MOH Respite Study, *supra* note 535.

<sup>930</sup> My Aged Care Website, *supra* note 159; Health Direct Website, *supra* note 760; Carer Gateway Website, *supra* note 722.

<sup>931</sup> ACA, *supra* note 160 at s 44-3; *Fees and Payments Principles 2014 (No 2)* (Cth) s 10; My Aged Care Website, *supra* note 159.

<sup>932</sup> O'Connell et al., *supra* note 194 at 113-114.

<sup>933</sup> O'Connell et al., *ibid* at 115-116.

<sup>934</sup> O'Connell et al, *ibid* at 111-112, 114-115; Williams & Owen, *supra* note 194 at 40.

First, if caregivers do not have other family members or the formal care to give them a break, women will be restricted in what they can do in their own lives, from engaging in paid employment to taking care of their own health. Women may not be able to take on positions where they need to work many hours or work unpredictable hours because of the need to be available to care. Increased respite care would help enhance a woman's autonomy because she would have more options and opportunities, even if most women still lack the option of whether they are caring at all. A woman would be able to engage in a wider range of paid employment and the ability to choose how she spends the other time in her life, whether she chooses to provide care work or engage in other pursuits.

Relational autonomy posits that state regulation can increase autonomy, especially for those who may be in oppressed situations.<sup>935</sup> Respite care provided by the government would be especially important for those women who may be in oppressive situations such as those with limited social networks or family members to help them, living in rural areas, having low incomes, or lacking employment leaves or flexible work options. These caregivers have fewer options for balancing paid work and care work, so the government could enhance their choices by providing more extensive respite care through a variety of forms of respite care, including short- and long-term.

Respite care is also important to maintain the relationship between caregiver and care recipient. Relational theory is based on assumptions of the importance of relationships in every person's life, and the fact that these relationships can be harmful or helpful to an individual.<sup>936</sup> There is a great deal of dependency involved in these caregiving relationships and often a power imbalance when one person is physically dependent on the other.<sup>937</sup> Giving respite care would aid the pair to have some time apart and interact with other people, such as the care recipient being able to engage in social activities in day programs, or the caregiver having time to maintain other relationships. This may help maintain both relationships with others, and relationships with each other. Time apart may help reduce stresses in the care relationships due to the power and dependency imbalance that may exist, especially between a parent and child who see a shift in power from their pre-care relationship. Research has also shown that the care

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<sup>935</sup> Nedelsky, *supra* note 317 at 65, 131-132.

<sup>936</sup> Llewellyn & Downie, *supra* note 318 at 4-6; Nedelsky, *ibid* at 19-20.

<sup>937</sup> Sherwin & Winsby, *supra* note 18 at 185-186 ; Nedelsky, *ibid* at 26-29.

burdens are lower when there is a sense of reciprocity;<sup>938</sup> government-provided respite care, along with other government supports for caregivers, may help the care recipient feel less of an imbalance in the relationship as the caregiver is being compensated and valued for this work.

### **Direct Payments for Caregivers**

Australia has larger and more direct payments for caregivers than Canada, although the availability of these payments is limited for caregivers who are not caring full-time.<sup>939</sup> Ontario does not have any direct payments for caregivers, and the only direct payment available in BC is from a care recipient who is receiving money through the CSIL program to pay a caregiver.<sup>940</sup> This program is of limited use for caregivers, because immediate family members are generally not eligible to be paid through CSIL, and these would represent the majority of caregivers.<sup>941</sup> However, the protection mechanism of requiring respite care be a part of the care plan is a good step because it allows caregivers who could be providing a great deal of care work to get rest.

Nova Scotia's caregiver benefit is a good start to compensating caregivers financially.<sup>942</sup> The \$400 a month payment<sup>943</sup> would be a good way for caregivers to supplement paid employment to compensate for the times that they have reduced employment income, are on unpaid leave to care, or are in precarious employment. However, due to the need to provide 20 hours of care work per week to be eligible,<sup>944</sup> the conditions are too restrictive because these caregivers would likely not be able to be employed full-time, or may have reduced employment income. Because the program requires the care recipient to have a low income,<sup>945</sup> this program would not aid those caring for someone with a higher income but who still cannot afford to pay for care, or would prefer to have a family member caring for them. The fact that caregivers are allowed limited time off without losing the benefit<sup>946</sup> is important to ensure caregivers can take time off to care for themselves or attend to paid employment. However, authors have noted that if payments are too low that these payments may not help women get higher financial security

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<sup>938</sup> Reid, Moss, & Hyman, *supra* note 198 at 186-187, 192.

<sup>939</sup> The Carer Allowance provides A\$63.55 per week, the Carer Payment provides A\$447.20, and the Carer Supplement is A\$600 per year (Carer Payments Website, *supra* note 759).

<sup>940</sup> BC H&CC Website, *supra* note 436; Best of Care, *supra* note 16 at 40-41; BC H&CC Policy Manual, *supra* note 16 at 4.C.3.

<sup>941</sup> BC H&CC Policy Manual, *ibid* at 4.C.4.

<sup>942</sup> NS Caregiver Benefit Website, *supra* note 609; Caregiver Benefit Program Policy, *supra* note 609 at 1-3.

<sup>943</sup> Caregiver Benefit Program Policy, *ibid* at 3.

<sup>944</sup> Caregiver Benefit Program Policy, *ibid* at 2.

<sup>945</sup> Caregiver Benefit Program Policy, *ibid* at 2; NS Caregiver Benefit Website, *supra* note 609.

<sup>946</sup> Caregiver Benefit Program Policy, *ibid* at 3-4.



and they may be pressured to leave paid work to perform care work.<sup>947</sup>

Australia does have significantly more direct payments than Canada, although like Nova Scotia's Caregiver Benefit, the payments are most often limited to those caring full-time and thus not widely useable. The Carer Allowance is the most likely to help the widest range of caregivers because it does not have an income or asset maximum,<sup>948</sup> so caregivers can maintain paid employment, which is important because the allowance amount is low at A\$63.55 per week.<sup>949</sup> Additionally, the lack of a maximum number of hours she can work is an important aspect of allowing the caregiver to maintain paid employment. The lack of a specific number of hours of care work per week required allows the caregivers to take temporary breaks for care work, and allows for ebbs and flows in the number of hours of care work. The backdating of the carer allowance<sup>950</sup> is also a strong aspect of the program because caring may come on suddenly.

The Carer Payment may not be useable by most caregivers for several reasons. The income and asset maximums and limits on hours of paid work or school<sup>951</sup> mean that caregivers cannot work many hours to supplement their carer payment. Even if a caregiver can find a workplace with sufficient flexibility to allow them to engage in paid work and care work for a high number of hours, they would be excluded from this paid work if they wish to maintain the carer payment. The dollar amount of the carer payment, A\$894.40 per two weeks, would be a decent support if the caregiver were also in paid employment, but if a caregiver were relying on the carer payment alone this would leave the caregiver right around the poverty line.<sup>952</sup> The Carer Supplement is a beneficial add-on to the other payments to compensate caregivers for out of pocket expenses for care work.<sup>953</sup> It is useful that caregivers do not have to apply separately for the payment<sup>954</sup> because this would reduce the steps required and make it more likely they will receive it.

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<sup>947</sup> Keefe & Rajnovich, *supra* note 268 at 83-84.

<sup>948</sup> Carer Payments Website, *supra* note 759.

<sup>949</sup> Carer Payment Website, *ibid*; SSA, *supra* note 793 at s 974, 981. The Australian dollar is roughly equivalent to the Canadian dollar.

<sup>950</sup> Carer Payments Website, *ibid* – the allowance can be backdated for up to 12 weeks to account for care starting suddenly.

<sup>951</sup> Carer Payments Website, *ibid*; SSA, *supra* note 793 at s 198B, 198D – for care recipients, the income cap is A\$112,006 and asset cap is A\$691,000; for caregivers the asset cap is A\$253,750, and they cannot work or attend school for more than 25 hours per week.

<sup>952</sup> Carer Payments Website, *ibid*; Australian Council of Social Services Website, "Poverty" online: <[www.acoss.org.au/poverty-2/](http://www.acoss.org.au/poverty-2/)> [ACOSS].

<sup>953</sup> Carer Payment Website, *supra* note 759; SSA, *supra* note 793 at s 992X.

<sup>954</sup> Carer Payment Website, *ibid*; SSA, *ibid* at s 992X.



The BCLI report strongly favors Australia’s approach to providing payments to caregivers.<sup>955</sup> The report notes this program’s ability to acknowledge caregivers of all income levels, and argues the Carer Payment provides a “significant” amount of income for caregivers compared to what other countries provided and would cover the basic costs.<sup>956</sup> However, estimates in Australia would put this amount at the poverty line, excluding the carer supplement.<sup>957</sup> While providing a similar payment in Canada would be a step forward, caregivers would still need to engage in paid employment or have a spouse with employment income to ensure they do not remain at the poverty line. Even if the payments in Australia are more than other countries as BCLI argued, they are still insufficient on their own.

Keefe and Rajnovich, in discussing financial compensation for caregivers in other countries, argue that direct payments are one method that could be used in Canada, in conjunction with other supports, to help value women’s work and compensate them for their care work.<sup>958</sup> They argue that policies such as Australia’s are used by the government both to encourage informal care work and compensate women for the financial impacts they experience – both reducing health care costs and recognizing caregivers and placing social value on this work.<sup>959</sup> In discussing these policies, the authors note that payments for caregivers can have some opposite effects than intended, including concerns that payments may not reduce the gendered nature of care work because they encourage women who are already facing lower wages than men to engage in care work while not sufficiently correcting the income disparities.<sup>960</sup> On the other side, Keefe and Rajnovich describe that these policies can also help caregivers by recognizing their caregiving labour, which they actually have little choice but to undertake.<sup>961</sup> Caregiver payments can allow women more autonomy because they may be less reliant on a spouse for financial security.<sup>962</sup> They describe these payments as “...a matter of gender justice.”<sup>963</sup> Discussing payments given to the care recipient to pay for caregivers, they note that these programs are beneficial because they “...can provide autonomy and flexibility for

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<sup>955</sup> BCLI, *supra* note 3 at 84.

<sup>956</sup> BCLI, *ibid* at 84.

<sup>957</sup> ACOSS, *supra* note 952.

<sup>958</sup> Keefe & Rajnovich, *supra* note 268 at 86-87.

<sup>959</sup> Keefe & Rajnovich, *ibid* at 82-83.

<sup>960</sup> Keefe & Rajnovich, *ibid* at 83-84.

<sup>961</sup> Keefe & Rajnovich, *ibid* at 84.

<sup>962</sup> Keefe & Rajnovich, *ibid* at 84.

<sup>963</sup> Keefe & Rajnovich, *ibid* at 84.

both caregivers and care receivers...»<sup>964</sup>

Giving payments to caregivers in Canada would increase autonomy and decrease oppression for caregivers and aid the relationship with the care recipient. Payments would help care receivers because it would give women with low incomes due to care work an increased amount of money which is theirs alone. Women may be less economically reliant on a partner or other family members. An increase in financial security may give women more autonomy in terms of giving them more options in how they spend time. Giving direct payments to caregivers may not give women more choice in whether they care or not – Keefe and Rajnovich argued that giving payments to caregivers may encourage women to reduce employment because there is a financial benefit to this.<sup>965</sup> Reinforcing the pressure to leave paid employment to perform care work would not be giving women more choice, which would be a negative result. Giving payments would however give a tangible recognition of the importance of this care work to society and the health care system, which is an important value in relational autonomy.<sup>966</sup> Australia's payments only being offered to low income caregivers targets the most oppressed groups of women, who may have fewer options in caring due to an inability to pay for care and not having access to jobs with sufficient flexibility to balance paid work and care work. Payments may increase this at-risk group's income. However, this would not aid caregivers who do not have a low enough income to qualify, and those who desire to be employed are restricted in doing so if they want to receive the payments.

Stoljar has argued that these oppressive circumstances can be problematic for carers because they may internalize the beliefs that come with these oppressive roles, such as that women should be the ones providing care work.<sup>967</sup> Providing payments as incentives for providing unpaid care work and restricting paid work may encourage women to provide care work and encourage the gendered division of care work. Payments are important for ensuring that women who are already in these circumstances do have sufficient income so that they have more autonomy in the rest of their lives. However, other societal changes such as the division of care labour and employment regulations are needed to correct the other conditions which require

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<sup>964</sup> Keefe & Rajnovich, *ibid* at 85.

<sup>965</sup> Keefe & Rajnovich, *ibid* at 83-84.

<sup>966</sup> Keefe & Rajnovich, *ibid* at 84; Sherwin & Winsby, *supra* note 18 at 185-186; Nedelsky, *supra* note 317 at 28-29.

<sup>967</sup> Stoljar, *supra* note 383 at 379; Sherwin & Winsby, *ibid* at 185.

women to care.<sup>968</sup>

Direct payments to caregivers would aid care recipients as well. Seniors who are dependent on family for care often feel a lack of reciprocity that may harm the relationship with the care recipient.<sup>969</sup> If the caregiver receives direct payment, the elder may feel less of a sense of burden on the rest of the family because the caregiver is not experiencing as severe financial repercussions from providing this care work. A sense of reciprocity may be more readily obtained, which may help make the care relationship less stressful.

### **Retirement Income Sufficiency**

Canada does not specifically provide pension supports for caregivers, although caregivers can utilize the public pillars of the pension system (OAS, GIS, as well as CPP if they have engaged in paid employment) if care work has led them to have a lower pension entitlement; Australia in contrast does have some retirement support specifically for caregivers.<sup>970</sup> Australia's carer payment can be taken into retirement age,<sup>971</sup> which does allow some compensation for caregiver's lost retirement income. Being able to choose the carer payment or age pension is helpful for caregivers because both programs provide the same level of income, but the age pension allows for fewer bureaucratic hurdles.<sup>972</sup> As well, if caregivers have reduced caring responsibilities as they reach old age themselves, being able to switch to the age pension allows caregivers to maintain the same income level as before they were 65 while still reducing their care hours. If care were to cease altogether in old age, this also ensures caregivers are not left without any retirement income. However, like the Carer Payment, this amount would still leave the caregiver at the poverty line.<sup>973</sup>

In Canada, caregivers would have to rely on the existing public pillar of the pension system if they have reduced or no pension entitlement due to their caregiving responsibilities. Scholars in Canada have discussed the problems with the pension system for informal caregivers and made suggestions for expanding the public pension system to address the deficits faced by informal caregivers. Women already have greater reliance on the public pension system due to

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<sup>968</sup> Sherwin & Winsby, *ibid* at 185.

<sup>969</sup> Reid, Moss, & Hyman, *supra* note 198 at 186-187, 192.

<sup>970</sup> BCLI, *supra* note 3 at 88-90, 94. The public pillars of the Canadian pension system are the first pillar of OAS and GIS, and the second pillar of CPP. The third pillar are private pensions. Kodar, Pension (In)Securities, *supra* note 68 at 96-99; Woodman, *supra* note 268 at 132, 138; Yong, *supra* note 268 at 667-668.

<sup>971</sup> Carer Payments Website, *supra* note 759; SSA, *supra* note 793 s 43.

<sup>972</sup> Carer Payments Website, *ibid*; SSA, *ibid* at s 43.

<sup>973</sup> ACOSS Website, *supra* note 952.

the fact that they take time out of the workforce to care for both children and adult family members.<sup>974</sup> Adding to this reliance is the fact that women are more often in precarious employment which commonly does not have workplace pensions or stability, and have less employment income to invest in private pension vehicles.<sup>975</sup> The OAS and GIS do not require any ties to paid employment so would be helpful to low income caregivers who do not have other pensions, but the dollar value of these pensions would leave women in poverty.<sup>976</sup>

Canadian authors have discussed the way the pension system in Canada overall treats women – pension systems tend to look at the family overall, so women’s individual retirement sufficiency is not often examined.<sup>977</sup> Women’s unpaid work is unaddressed in pension entitlements.<sup>978</sup> Women who have not engaged in paid employment are left relying on a spouse’s pension, or a public pension such as OAS or GIS.<sup>979</sup> Yong and Woodman have both argued that partially due to changing family situations it is not always true that women have a spouse’s income to rely on.<sup>980</sup> These assumptions of having a spouse’s income in retirement also reduce a woman’s autonomy in that she does not have any income of her own.<sup>981</sup> Income splitting rules, while seeming to compensate women, may actually lead to women retiring early to perform care work to take advantage of this tax savings method, leading to lower personal retirement income.<sup>982</sup> Retirement income sufficiency for women has not been the focus of current pension debates in the country; instead, the debates have been focused on bolstering private pension vehicles.<sup>983</sup> In focusing on private pensions, some reformers argue that Canadians can choose to save however much they need for the standard of living they want to have, but this ignores that fact that women may not have the same choices as men.<sup>984</sup>

Women’s entitlement to CPP is greatly reduced due to their disrupted employment

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<sup>974</sup> Report of the Standing Committee, *supra* note 96 at 16-17; Kodar, Pension (In)Securities, *supra* note 68 at 97; Spencer & Soden, *supra* note 900 at 10-12; Yong, *supra* note 268 at 664-665; Woodman, *supra* note 268 at 135, 138.

<sup>975</sup> ; McDonald, *supra* note 7 at 157; Kodar, Pension (In)Securities, *ibid* at 93-94; Yong, *ibid* at 664-665; Woodman, *ibid* at 135; Report of the Standing Committee, *ibid* at 6-7.

<sup>976</sup> McDonald, *ibid* at 158; Report of the Standing Committee, *ibid* at 11-14; Kodar, Pension (In)Securities, *ibid* at 96-97; BCLI, *supra* note 3 at 90; Spencer & Soden, *supra* note 900 at 12; Yong, *ibid* at 667. The OAS is up to \$586.66 per month, and the GIS is up to \$876.23 per month (Canada, OAS Payment Amounts, *supra* note 151).

<sup>977</sup> Woodman, *supra* note 268 at 131-133.

<sup>978</sup> Woodman, *ibid* at 132.

<sup>979</sup> Yong, *supra* note 268 at 678-681.

<sup>980</sup> Yong, *ibid* at 679-681; Woodman, *supra* note 268 at 134.

<sup>981</sup> Woodman, *ibid* at 134; Yong, *ibid* at 681.

<sup>982</sup> Woodman, *ibid* at 153; Yong, *ibid* at 678-679.

<sup>983</sup> Kodar, Pensions and Unpaid Work, *supra* note 268 at 180-182.

<sup>984</sup> Woodman, *supra* note 268 at 140.

histories and lower employment incomes.<sup>985</sup> This part of the pension system has been a frequent target of reform possibilities for Canadian scholars. Drop-outs have been suggested as a method of bolstering caregivers' retirement income.<sup>986</sup> For example, the BCLI report, along with other authors, note the child-rearing drop-out and the low-earning drop-out provide a framework to create a drop-out for unpaid care of an adult.<sup>987</sup> The CPP replacement rate could be increased to provide a higher amount of retirement income.<sup>988</sup> As well, the CPP could provide credits for unpaid work, so women accrue public pensions for their care work.<sup>989</sup> Authors and reports have suggested raising the GIS and OAS levels to be above the low-income cut-off, which would help those women relying on these due to a lack of employment-related pensions.<sup>990</sup> However, Kodar notes that these reform potentials will never be completely effective at eliminating the gender differences in pensions because they do not correct the gender imbalance in employment, income, and unpaid care work.<sup>991</sup> For example, Kodar suggests creating flexible work practices and leaves to aid women in combining paid work and care work to increase pension entitlements.<sup>992</sup>

Like direct payments to caregivers, ensuring caregivers have retirement sufficiency of their own would help caregivers have more personal income so they have increased choices in other aspects of their life. However, similar concerns may exist such as caregivers retiring early to care for aging relatives. In the long run, increasing the personal retirement sufficiency of women may help women in the future have more options. Without adequate retirement income, women who care may in turn be more dependent on family members to care for them because they may not have enough income to pay for private care when the public system is lacking. This may reinforce the care cycle and the lack of choices for subsequent generations of women. With more income, women have more care choices in their own retirement – they may get care

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<sup>985</sup> Report of the Standing Committee, *supra* note 96 at 16-17; Kodar, Pension (In)Securities, *supra* note 68 at 97; Yong, *supra* note 268 at 667-668.

<sup>986</sup> BCLI, *supra* note 3 at 91-92; Woodman, *supra* note 268 at 146; Kodar, Pension (In)Securities, *ibid* at 99; Report of the Standing Committee, *ibid* at 19.

<sup>987</sup> BCLI, *ibid* at 91-92; Woodman, *ibid* at 146; Kodar, Pension (In)Securities, *ibid* at 97; Report of the Standing Committee, *ibid* at 17-18.

<sup>988</sup> Yong, *supra* note 268 at 682; Woodman, *ibid* at 145-146; Kodar, Pension (In)Securities, *ibid* at 99; Report of the Standing Committee, *ibid* at 32.

<sup>989</sup> Yong, *ibid* at 681; Report of the Standing Committee, *ibid* at 18.

<sup>990</sup> Yong, *ibid* at 681; Kodar, Pension (In)Securities, *supra* note 68 at 99; Report of the Standing Committee, *ibid* at 14.

<sup>991</sup> Kodar, Pension (In)Securities, *ibid* at 100.

<sup>992</sup> Kodar, Pension (In)Securities, *ibid* at 100.

from the public system, pay for home care or supportive long-term care, or if they and the carer choose, receive care from family members. This future retirement sufficiency may increase autonomy and choices for both the caregiver and the future care receiver.

### **Leaves and Workplace Flexibility**

There are a great many similarities between Canada and Australia's care leaves, although Australia takes a more legislated approach to giving caregivers access to workplace flexibility. BC's Family Responsibility Leave is useful for those engaged in caring for seniors as it covers the majority of family members and it cannot be denied.<sup>993</sup> However, the ability to carry over unused days into the next year like the Australian leave<sup>994</sup> would be useful because it would allow caregivers to bank unused days for years when care needs may be higher or for emergencies where care needs are temporarily very high and unanticipated. The lack of paid leave<sup>995</sup> would impact a caregiver's financial security. BC's Compassionate Care Leave is a good method for long-term leave when a family member needs significant care due to a terminal illness, and the definition of family is sufficiently broad to include most family members.<sup>996</sup> The fact that advance notice does not need to be given<sup>997</sup> is helpful for caregivers because they may not have warning if caring starts due to a medical emergency. However, this extended leave is of limited utility for the majority of caregivers of the elderly because the care recipient must have a terminal illness. A longer-term leave for those who are not dying but may be experiencing a serious medical or chronic illness would be helpful because there may be increased caring needs but no employment protection for the caregiver.

Ontario's Family Medical Leave is similar to BC's Compassionate Care Leave, including an inclusive list of family members who could need care.<sup>998</sup> It is also important this leave can be used for those in precarious employment.<sup>999</sup> Ontario's Family Caregiver Leave fills a gap in BC's leave structure because it allows for a longer-term unpaid leave without the requirement for

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<sup>993</sup> BC ESA Interpretation Guidelines, *supra* note 549 at s 52 Family Responsibility Leave; BC ESA, *supra* note 550 at s 52, 54, 56.

<sup>994</sup> BC ESA Interpretation Guidelines, *ibid* at s 52 Family Responsibility Leave; Carer Leaves Website, *supra* note 832.

<sup>995</sup> BC ESA, *supra* note 550 at s 52.

<sup>996</sup> BC ESA Interpretation Guidelines, *supra* note 549 at s 52.1 Compassionate Care Leave; BC ESA, *ibid* at s 52.1; BC Reg 281/2006, *supra* note 560 at s 2; BCLI, *supra* note 3 at 27-28.

<sup>997</sup> BC ESA Interpretation Guideline, *ibid* at s 52.1 Compassionate Care Leave; BC ESA, *ibid* at s 52.1.

<sup>998</sup> Ont ESA Guide, *supra* note 579 at Family Medical Leave; Ont ESA, *supra* note 577 at s 49.1; O Reg 476/06 s 1.

<sup>999</sup> Ont ESA Guide, *ibid* at Family Medical Leave.

imminent risk of death.<sup>1000</sup> Being unpaid, it would leave caregivers with a significant loss of income if they were to take the whole leave each year. However, the employment protection is important so that caregivers have a job to go back to after the leave. The fact that caregivers can take the leave for emotional or physical care would lead to this being available for a wide number of caregivers, including those who pay out of pocket for most of the physical care. This leave could be more helpful for caregivers if it could be taken in increments of less than a week to help with more of the ongoing care needs, rather than the more intensive health care incidents. However, the personal emergency leave is available for shorter caregiving.<sup>1001</sup> It is beneficial that this leave allows for planned surgeries because there would likely be increased care load at this time, as well as being able to care for emotional emergencies of the care recipient.<sup>1002</sup> However, the fact that this leave can only be taken by those working for bigger employers<sup>1003</sup> is problematic due to the fact that many caregivers may not be able to take this shorter leave to deal with daily caregiving needs. The inclusion of caregivers in precarious employment<sup>1004</sup> improves the coverage of this leave.

The BCLI report notes that the leaves are not widely used by caregivers – only 20% of caregivers used a form of unpaid leave.<sup>1005</sup> Half of surveyed caregivers had to use their sick or vacation time to care.<sup>1006</sup> The report found caregivers wanted more leaves, both paid and unpaid, and consultations also suggested adding more care-related benefits.<sup>1007</sup> Martin found that just under a quarter of employees had access to flexible work arrangements in Canada, and those that did have these benefits available to them were in jobs with overall more benefits, such as management positions.<sup>1008</sup> Paid leaves from the employer were not typically at full salary.<sup>1009</sup> Current approaches to encouraging workplaces to offer more flexibility have focused on arguing that their employees will be more efficient if they are able to balance paid work and care

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<sup>1000</sup> Ont ESA Guide, *ibid* at Family Caregiver Leave; Ont ESA, *supra* note 577 at s 49.3.

<sup>1001</sup> Ont ESA, *ibid* at s 50.

<sup>1002</sup> Ont ESA Guide, *supra* note 579 at Personal Emergency Leave.

<sup>1003</sup> Ont ESA, *supra* note 577 at s 50 – the employer must have at least 50 employees between all of their locations.

<sup>1004</sup> Ont ESA Guide, *supra* note 579 at Personal Emergency Leave.

<sup>1005</sup> BCLI, *supra* note 3 at 24.

<sup>1006</sup> BCLI, *ibid* at 24.

<sup>1007</sup> BCLI, *ibid* at 24, 33.

<sup>1008</sup> Martin, *supra* note 299 at 511-512, 516-517.

<sup>1009</sup> Martin, *ibid* at 510.



work.<sup>1010</sup> Martin argues that current labour law regards care work as a family issue only.<sup>1011</sup> To correct the harms from balancing paid work and care work, society needs to change its view of paid work and care work.<sup>1012</sup> Martin posits that care work should be seen as valuable and not a completely separate sphere from employment.<sup>1013</sup>

The federal Compassionate Care Benefit (CCB) does allow caregivers to receive an income while caring for a terminally ill family member, and does mirror the provincial leaves.<sup>1014</sup> The CCB payments may encourage caregivers to utilize the provincial unpaid leave if they do not have to be as concerned about a loss of income while also having job security. But, caregivers still do not receive their full income under this benefit<sup>1015</sup> so they will still have reduced employment income during this period. The qualifying hour requirement,<sup>1016</sup> while not requiring full-time employment, could mean that caregivers in precarious employment or who have had to take a lot of time away from paid employment in the past year to care would not be able to receive it, and this group may be most in need.<sup>1017</sup> The majority of individuals using this program are women.<sup>1018</sup> Flagler and Dong argue that the CCB is limited in its usefulness for caregivers because many people do not know that this benefit is available.<sup>1019</sup> The financial cost of the application and the translation services may be too high for some.<sup>1020</sup> The list of eligible family members is not large enough because it does not include friends for whom the applicant may be the only caregiver.<sup>1021</sup> Flagler and Dong argue the program should be extended because the number of weeks is not sufficient for the care needs, and the increased cost of expanding the program could be compensated for because fewer people would utilize hospital and palliative care if informal caregivers took more time off to care for their dying relatives.<sup>1022</sup>

The BCLI report argues that Australia's employment leave scheme is more limited than

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<sup>1010</sup> Martin, *ibid* at 510-511; In Australia, these economic arguments have also been presented for attempting to achieve more flexible workplace practices: Smith, *Baby with the Bathwater*, *supra* note 302 at 692.

<sup>1011</sup> Martin, *ibid* at 518-520.

<sup>1012</sup> Martin, *ibid* at 518-520.

<sup>1013</sup> Martin, *ibid* at 518-520.

<sup>1014</sup> EI CC Website, *supra* note 623; *EIA*, *supra* note 624 s 23.1 - The caregiver can also be on a provincial compassionate care leave, which protects them from being terminated or penalized.

<sup>1015</sup> EI CC Website, *ibid*.

<sup>1016</sup> EI CC Website, *ibid*.

<sup>1017</sup> BCLI, *supra* note 3 at 30; Flagler & Dong, *supra* note 268 at 55-56.

<sup>1018</sup> Flagler & Dong, *ibid* at 55.

<sup>1019</sup> Flagler & Dong, *ibid* at 55.

<sup>1020</sup> Flagler & Dong, *ibid* at 55.

<sup>1021</sup> Flagler & Dong, *ibid* at 56.

<sup>1022</sup> Flagler & Dong, *ibid* at 56-57.

Canada's.<sup>1023</sup> Australia does have a small paid leave, the Sick and Carer's Leave.<sup>1024</sup> While this does give a limited paid leave to caregivers, this leave being for both care work and personal sick time<sup>1025</sup> means that if employees use up the leave for care work, they may not have paid leave to care for themselves. The carry-over of unused days<sup>1026</sup> is useful for caregivers so that they can save days for when caregiving loads are higher. However, the exclusion of casual employees<sup>1027</sup> would leave out a large number of caregivers in precarious employment or those that need to move to casual work to accommodate care work. The unpaid carer's leave is similar to Canada's Family Responsibility Leave, except there are not a limited number of days per year that can be taken.<sup>1028</sup> The ability to use leave as needed means caregivers can take leave without having to prioritize their care work over their employment status. Australia's Compassionate Leave is significantly less time than the Canadian provincial leaves – two days per illness versus eight weeks per illness, although these two days are paid leave.<sup>1029</sup> Two days may not be sufficient time for caregivers to spend with their relative, both for emotional and physical care.

Where Australia does provide more protection than Canada is in the area of workplace flexibility legislation. Few Canadians have access to flexible work arrangements; this is especially true of women, who are more likely to work in jobs where there is not this opportunity.<sup>1030</sup> The Canadian Human Rights Commission's report on how to balance paid work and care work puts a great burden on caregivers to establish that she has no choice but to engage in care work and that she has made all other alternative arrangements possible.<sup>1031</sup> Women may not have a choice but to engage in care work, yet this guide seems to assume that employees are likely to be choosing to care, and this choice means that they do not need to be accommodated. Proving care is an obligation, not optional, may be a difficult hurdle to pass.

Australia does require in its *FWA* that employees have a right to request flexible work arrangements.<sup>1032</sup> Having legislated this right is important because it would better allow caregivers to balance paid work and care work without having to prioritize one over the other.

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<sup>1023</sup> BCLI, *supra* note 3 at 35.

<sup>1024</sup> Carer Leaves Website, *supra* note 832.

<sup>1025</sup> Carer Leaves Website, *ibid*; *FWA*, *supra* note 833 s 96, 97.

<sup>1026</sup> Carer Leaves Website, *ibid*.

<sup>1027</sup> Carer Leaves Website, *ibid*; *FWA*, *supra* note 833, s 96.

<sup>1028</sup> Carer Leaves Website, *ibid*; *FWA*, *ibid*, s 102, 103.

<sup>1029</sup> Carer Leaves Website, *ibid*; *FWA*, *ibid*, s 105, 106.

<sup>1030</sup> BCLI, *supra* note 3 at 40.

<sup>1031</sup> CHRC Guide, *supra* note 645 at 5-6.

<sup>1032</sup> Flexible Work Arrangements Website, *supra* note 859; *FWA*, *supra* note 833, s 65.

However, the right to request flexible work arrangements is not without flaws. The most common type of flexible work arrangement in both Canada and Australia is changing to part-time work,<sup>1033</sup> although this may not be the type of flexible arrangements caregivers want, as this would lead to a decrease in income. Caregivers do not have practical access to work practices that would maintain their income level but allow them to better fit in care work, such as working from home or working at different hours of the day.<sup>1034</sup> As well, while Carers Australia may help some caregivers with the process of requesting flexible work arrangements,<sup>1035</sup> there are few other supports to help caregivers in negotiations. In any extent, these structures do not exist in Canada. Smith has argued that workplace flexibility does not help those who actually want more standardized hours so that they can consistently be available to care; flexibility tends to promote less standardized work hours.<sup>1036</sup> Pocock, Charlesworth, and Chapman note this right may not be well-known in Australia – only around a quarter of people knew about the FWA request mechanism after it was enacted, and the number of people requesting a change in employment circumstances did not change after it was introduced.<sup>1037</sup> This demonstrates these rights are not useful to caregivers if they do not know about them. Additionally, these rights may not be as useful for those in casual or part-time employment.<sup>1038</sup>

Employers can refuse a flexible work request on reasonable business grounds,<sup>1039</sup> which may be difficult for caregivers to challenge. Fighting a decision may require going to court, which may be too expensive and time consuming for most caregivers.<sup>1040</sup> Currently, there is no easier method of challenging the decision, such as appealing to a tribunal.<sup>1041</sup> Chapman notes that caregivers cannot argue against the reason for refusal, they can only challenge the process of the request.<sup>1042</sup> Chapman also argues that if the employer does not implement the bargain, caregivers may be left with no remedies.<sup>1043</sup> The processes of negotiations to achieve an agreement are also not adequately reflected in the legislation - there is no structure for a process

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<sup>1033</sup> Hill et al, *supra* note 203 at 29-30; BCLI, *supra* note 3 at 39-40.

<sup>1034</sup> Baird, Williamson, & Heron, *supra* note 302 at 329-330.

<sup>1035</sup> Carers ACT Website, *supra* note 882.

<sup>1036</sup> Smith, FWA, *supra* note 302 at 570-571.

<sup>1037</sup> Pocock, Charlesworth, & Chapman, *supra* note 302 at 601-602.

<sup>1038</sup> Pocock, Charlesworth & Chapman, *ibid* at 601.

<sup>1039</sup> FWA, *supra* note 833, s 65.

<sup>1040</sup> BCLI, *supra* note 3 at 61; Smith, It's About Time, *supra* note 302 at 132-133.

<sup>1041</sup> Pocock, Charlesworth & Chapman, *supra* note 302 at 602; Smith, FWA, *supra* note 302 at 571.

<sup>1042</sup> Chapman, Reasonable Accommodation, *supra* note 302 at 51.

<sup>1043</sup> Chapman, Reasonable Accommodation, *ibid* at 50-51.

of negotiating if the first request is denied.<sup>1044</sup>

Several authors have argued that in general, labour law in Australia, including the above discussed leaves, does not sufficiently deal with gender.<sup>1045</sup> Labour law is based on a supposedly gender neutral framework; however, this framework is actually not gender neutral, as it assumes the ideal worker does not have caring responsibilities that will take time away from paid work.<sup>1046</sup> Women are not adequately included within this framework because they often spend time outside the workforce performing care work.<sup>1047</sup> Labour laws keep women subjugated due to the bias toward typically male patterns of work, such as requiring a consistent history of working with the same employer before being eligible for leaves, paid or unpaid.<sup>1048</sup> Smith argues the *FWA* is moving in the right direction because it does start to accommodate care work within the workplace, but it does not go far enough because the male work model still permeates workforces and most of the law.<sup>1049</sup> Women are also still subjugated to the role of non-standard workers because programs such as flexibility requests make them stand out as a group needing special accommodations, not as asking for something all workers need regardless of gender.<sup>1050</sup> While Smith notes that providing more flexible work arrangements will not in itself correct the gender imbalance of paid work and care work, this may nonetheless start to encourage a societal shift in care work by reducing the cost of care work on women.<sup>1051</sup>

Jacobs et al. argues for increasing workplace flexibility from an economic perspective.<sup>1052</sup> The authors note that care work does cost the Canadian government money each year.<sup>1053</sup> Comparing costs to government as well as savings, the authors found that low intensity caregivers did not cost the government money, but high intensity caregivers cost the government \$641 million per year, due to the fact that caregivers could not work as much and thus paid less

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<sup>1044</sup> Chapman, Reasonable Accommodation, *ibid* at 50-51.

<sup>1045</sup> Smith, *FWA*, *supra* note 302 at 547-548; Baird, Williamson & Heron, *supra* note 302 at 328-329; Pocock, Charlesworth & Chapman, *supra* note 302 at 608.

<sup>1046</sup> Smith, *FWA*, *ibid* at 547-549; Baird, Williamson & Heron, *ibid* at 328-329; Pocock, Charlesworth & Chapman, *ibid* at 608.

<sup>1047</sup> Smith, *FWA*, *ibid* at 548-549

<sup>1048</sup> Smith, *FWA*, *ibid* at 556-558.

<sup>1049</sup> Smith, *FWA*, *ibid* at 567-568

<sup>1050</sup> Smith, *FWA*, *ibid* at 558.

<sup>1051</sup> Smith, Baby with the Bathwater, *supra* note 302 at 702.

<sup>1052</sup> Josephine C Jacobs, Meredith B Lilly, Carita Ng, & Peter C Coyte, "The fiscal impact of informal caregiving to home care recipients in Canada: How the intensity of care influences costs and benefits to government" (2013) 81 *Social Science & Medicine* 102 at 107-109.

<sup>1053</sup> Jacobs et al., *ibid*.

taxes.<sup>1054</sup> To lessen this loss, the authors argued that government should aim policies at high intensity caregivers, and increasing workplace flexibility was the best way for government to reduce the costs of high intensity care work.<sup>1055</sup>

Increasing the leave and workplace flexibility laws in Canada would give the most autonomy to caregivers. Leaves and flexibility are important in allowing women to choose whether they wish to maintain their current employment, change jobs, or leave work. Women still may not have complete freedom with respect to whether they engage in the care work. However, changing employment regulations would allow women not to have to choose between their own financial well-being and engaging in care work. However, the payments during leaves would have to be higher than those currently provided in Australia to provide sufficient income. Women would also have more autonomy because being able to maintain their current job, if they wish to do so, would lead them to likely maintain a higher income and retirement sufficiency than if they did not have the ability to request flexible work arrangements. If women have more choice in how they balance paid work and care work, this may also allow for a stronger relationship with the care recipient because caregivers do not have to worry about their income, have more freedom in how they lives their lives, and may not feel as constrained by being within this caring relationship.

Relational autonomy advocates that government action should give more autonomy to women.<sup>1056</sup> Government could mandate more flexible work options and increased paid or unpaid leave to employees, which would create a stronger balance and coverage for all women, as not all employers may voluntarily provide these workplace options. Government action may also push for societal changes in care work by showing leadership in providing respect for care work, and its importance within paid employment. Government would be able to directly provide more autonomy to women by giving them more choices in how to balance paid employment and unpaid care work. Australia is an example of how government can initiate more autonomous choices for women through their *FWA* request for flexible work practices. However, Canada currently provides more autonomy for women through its greater leave options both in the short and long term. Canada could further enhance autonomy by requiring paid leaves so that women do not have to take a reduction in wages if they need time off to care. Canada needs greater

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<sup>1054</sup> Jacobs et al., *ibid.*

<sup>1055</sup> Jacobs et al., *ibid.*

<sup>1056</sup> Nedelsky, *supra* note 317 at 65-72, 131-132.

workplace flexibility to allow women to maintain greater autonomy in their daily caregiving choices.

### **Tax Relief**

In both Canada and Australia, there is limited tax relief available to caregivers, and the tax relief itself is of limited use to caregivers. Canada's federal tax credit would be a form of financial assistance to caregivers.<sup>1057</sup> However, as the BCLI report has noted, the caregiver tax credit is non-refundable, which means if the taxpayer has too little or no taxes owing for that year, the credit goes partially or wholly unused and any unused portion is not paid out to caregivers.<sup>1058</sup> The credit is essentially symbolic in nature as most caregivers do not have sufficient income to use the tax credit due to their disrupted employment histories; further, it is primarily claimed by men.<sup>1059</sup> Only those caregivers with a high enough income can benefit from the tax credit, and this group may be less in need of it because they may be able to purchase care services to offset care work impacts, and be left to provide less intensive care work such as emotional support. Australia's Dependant Tax Offset would likely also pose challenges for caregivers seeking to make use of it due to the fact that it is also not refundable, so the credit remains unused if there are no taxes owing.<sup>1060</sup> The credit can be claimed by the spouse of the caregiver if the spouse maintains the caregiver, which means this credit may not be used by the actual caregiver.<sup>1061</sup> If the caregiver has too low an income to make use of the credit in Australia, the spouse could still benefit from the credit, but the credit does not go directly to compensating the caregiver for her care work. The caregiver is not receiving this credit under her own name. If the caregiver did get it under her own name, autonomy could be increased.

The BCLI report criticizes the Canadian tax credit for not requiring anyone to do actual care work to receive it – one simply has to live with a dependant, and there are no hours of care work required.<sup>1062</sup> Thus, the tax credit is not necessarily being used for its stated purpose of supporting caregivers.<sup>1063</sup> Australia's tax offset also faces this problem, in that one just has to reside with the dependant, so no care work may be required.<sup>1064</sup> The BCLI report does argue for

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<sup>1057</sup> *ITA, supra* note 637 s 118; CCC Website, *supra* note 637.

<sup>1058</sup> BCLI, *supra* note 3 at 67.

<sup>1059</sup> BCLI, *ibid* at 73.

<sup>1060</sup> Carer Tax Offset Website, *supra* note 869.

<sup>1061</sup> Carer Tax Offset Website, *ibid*; Cth *ITAA, supra* note 869, s 61-10, 61-20.

<sup>1062</sup> BCLI, *supra* note 3 at 73.

<sup>1063</sup> BCLI, *ibid* at 73.

<sup>1064</sup> Carer Tax Offset Website, *supra* note 869; Cth *ITAA, supra* note 869, s 61-10.

increased tax relief for caregivers due to the ease of using the tax system to deliver benefits and the fact that this would be tied to the concept of income, and notes refundable tax credits do exist in Quebec and Manitoba.<sup>1065</sup> Refundable tax credits would allow caregivers to receive a refund of whatever portion of the credit is left over after their tax liability is completely reduced.<sup>1066</sup>

The tax offsets available in Canada and Australia are not sufficient to aid caregivers from a relational autonomy perspective. The fact that the tax credit is not, in actuality, available to caregivers with low incomes who need it the most means that low-income women are not given as many opportunities to express autonomy as those individuals with higher income. Having a refundable tax credit would give an increasing number of women access to this tax offset, which would mean that women may have more income of their own. This group is already oppressed, and female caregivers lack the income and other social options that non-oppressed groups have.<sup>1067</sup> Caregivers have lower income due to their inability to fully participate in the paid workforce.<sup>1068</sup> Having a refundable tax offset would help low-income caregivers in precarious employment where they may have few leaves or flexible work options<sup>1069</sup> retain more disposable income that is truly under her own name and control, giving women more options in the lifestyle they wish to have. Tax offsets may not reduce the fact that women have to engage in care work, but it may give other options and reduce gender income imbalances.

### Community Resources

Community organizations for caregivers do exist in both countries, but Australia's are more widespread, offer more services, and can advocate on behalf of caregivers. There are several community groups in Canada that do provide services to caregivers, such as support groups and support phone lines and advocating for increased services for caregivers; however most of these organizations do not exist nationwide.<sup>1070</sup> Because these groups may be smaller or localized, this could reduce their ability to advocate nationally for caregiver supports under federal jurisdiction, and could reduce the ability to advocate in all provinces to create similar caregiver supports across the country. For example, Kodar argues that the lack of women's

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<sup>1065</sup> BCLI, *supra* note 3 at 74-78.

<sup>1066</sup> BCLI, *ibid* at 74-75.

<sup>1067</sup> Sherwin & Winsby, *supra* note 18 at 185.

<sup>1068</sup> CCEL Dialogue Project, *supra* note 129 at 75; Williams, *supra* note 14 at 7, 8; BCLI, *supra* note 3 at 64; ABS, 2012 DAC Survey, *supra* note 162; ABS, Caring in the Community, *supra* note 161.

<sup>1069</sup> BCLI, *supra* note 3 at 72-73.

<sup>1070</sup> The Family Caregiver, *supra* note 649; The Caregiver Exchange, *supra* note 649; Family Caregivers of BC, *supra* note 650; United Way Caregiver Handbook, *supra* note 650; Ontario Caregiver Coalition, *supra* note 651.



organizations in Canada, especially ones that exist country-wide, is a reason why women's concerns are not at issue in current pension debates, unlike the past when women's groups were more prevalent and women were a greater focus of pension reform.<sup>1071</sup> While these broad organizations supporting women caregivers are not direct government support for caregivers, they are a way for women to work together to receive the supports they need.

Australia does have a more centralized organization for supporting caregivers and advocating for legal and policy changes on their behalf – Carers Australia.<sup>1072</sup> While not created by the government, these caregiver organizations provide a lot of resources for caregivers, and the government has funded programs that are delivered through Carers Australia, such as counselling and respite services.<sup>1073</sup> These carer organizations, because they already provide caregivers support such as support groups and caregiver education,<sup>1074</sup> may become ideal locations to offer government caregiver supports due to the active involvement of caregiver stakeholders who know what fellow caregivers need. Australian research has found counselling and therapy to be beneficial to caregivers through reducing the emotional impacts of care work and increasing their caregiving skills.<sup>1075</sup> Stronger caregiver organizations across Canada could advocate for and provide further emotional and educational supports to help caregivers by fellow caregivers knowledgeable about their situation.

Australia's counselling services, training, and courses are important from a relational perspective because they give caregivers tools through which they can manage and improve their relationship with the care recipient. This could include skills to help communicate better with a care recipient whose illness has lessened communication abilities, which may help reduce tension. The fact that the counselling focuses on issues with the care recipient is very positive. This focuses the attention on ensuring the relationship between the caregiver and senior is successful so that the care work can be more sustainable; this in turn may allow the relationship to flourish. Dependency under relational theory is something which is a normal part of the life course and should not be ignored.<sup>1076</sup> Counselling and training may help caregivers better

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<sup>1071</sup> Kodar, Pension and Unpaid Work, *supra* note 268 at 202-203.

<sup>1072</sup> Carers ACT Website, *supra* note 882; Carers Australia Website, *supra* note 876; Carers NSW Website, *supra* note 891; Carers Vic Website, *supra* note 884; Carers Qld Website, *supra* note 884; Carers SA Website, *supra* note 884; Carers Tas, *supra* note 891; Carers WA, *supra* note 891; Carers NT, *supra* note 891.

<sup>1073</sup> Carers Vic Website, *ibid*; Carers NSW Website, *ibid*; Carers ACT Website, *ibid*.

<sup>1074</sup> Carers Vic Website, *ibid*; Carers ACT Website, *ibid*.

<sup>1075</sup> Williams & Owen, *supra* note 194 at 40.

<sup>1076</sup> Sherwin & Winsby, *supra* note 18 at 186-186; Nedelsky, *supra* note 317 at 27-29.

manage this dependency, as it may come with feelings of concern and sadness from both sides of the relationship, and may lead to tension. While counselling and training pose many benefits to both the caregiver and care recipient, this alone will not increase the autonomy of women because it does not give more options such as in whether care work is engaged in, how much care work is done, and what type of care is given. This counselling and training could, similar to Australia, be administered through provincial caregiver associations.

### **Access to Information for Caregivers**

In Canada, information for caregivers on caregiving skills, health information, and caregiver supports is sparse and found in disparate locations, while Australia has more centralized information. The caregiver tips on the BC website<sup>1077</sup> are fragmented and sparse, with basic tips only and few supports on how to balance paid work and care work. Health authorities do provide some more practical tips for providing hands on care work, and do link some community organizations for further help,<sup>1078</sup> but this information may vary by health authority, and the availability of the community resources may depend on what part of the province or country one lives in. Ontario does provide some basic information on respite services and tax credits for caregivers,<sup>1079</sup> but this information is not concentrated in any centralized location. Caregiver associations do exist in Canada and can provide information and resource to caregivers.<sup>1080</sup> Lilly et al. in a descriptive study found caregivers reported wanting more information from the health system about caring for individuals with specific health conditions, finding that their main source of information is caregiver organizations.<sup>1081</sup>

Australia, in comparison, does provide a great deal more information to caregivers through a variety of websites,<sup>1082</sup> but importantly the government runs the Carer Gateway which is a strong centralized resource.<sup>1083</sup> Caregivers can get the information either online or over the phone, and the information is specific to caregivers' needs, such as what supports are available

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<sup>1077</sup> Caring for Seniors Website, *supra* note 527.

<sup>1078</sup> Fraser Health Handbook, *supra* note 529.

<sup>1079</sup> Ont Respite Care Website, *supra* note 565; Ont H&CC Website, *supra* note 20; Seniors' Secretariat Guide, *supra* note 21.

<sup>1080</sup> The Family Caregiver, *supra* note 649; The Caregiver Exchange, *supra* note 649; Family Caregivers of BC, *supra* note 650; United Way Caregiver Handbook, *supra* note 650; Ontario Caregiver Coalition, *supra* note 651.

<sup>1081</sup> Lilly et al., *supra* note 540 at 107.

<sup>1082</sup> Australian Carers Information Website, *supra* note 758; Carer Payment Website, *supra* note 759; Health Direct Website, *supra* note 760; Department of Health Website, *supra* note 761.

<sup>1083</sup> Carer Gateway Website, *supra* note 722.

and information about how to give care.<sup>1084</sup> This website is important for supporting caregivers because it has all the information in one place, including links to the relevant places to obtain services, so caregivers do not have to search many different websites. This signals the importance of informal care work to the government, as it has taken the time to centralize caregiver resources. However, this information is not helpful to caregivers unless they know about it – studies and surveys in Australia have found that caregivers do not know about what services are available to help them in their caregiving role.<sup>1085</sup> As important as it is for information to be centralized and thorough for caregivers, they need to know about this website or phone line.

The lack of information is problematic from a relational perspective. In Canada, information is only shown for the senior's needs and so this does not demonstrate the importance of both sides of the relationship – seniors are not only dependent on the government, but also on the caregiver. The caregiver in turn may be dependent on the public health system for supports for herself as well, such as rest or personal health care. The relationship between care recipient and caregiver may be more balanced if both have easy access to information on health care and caregiver supports. Both care recipient and caregiver may have a stronger relationship if both have their needs cared for, and the focus is not solely on the care recipient. While there is information available from caregiver associations and these may be important sources of information for caregivers, this does not mean the government should not make a more centralized location for information provided by themselves and health authorities, like Australia's Carer Gateway.

### **Caregiver Recognition Legislation**

Australia has legislation which directly recognizes care work and its value to society in most of its jurisdictions, while Canada has little formal legislated recognition for caregivers. In Canada, Manitoba is the only province with a formal caregiver recognition act, which is similar to Australia's caregiver recognition legislation.<sup>1086</sup> Australia has significantly more, with each state and province as well as the Commonwealth Government having some form of caregiver

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<sup>1084</sup> Carer Gateway Website, *ibid*.

<sup>1085</sup> ABS, *Caring in the Community*, *supra* note 161; Stockwell-Smith et al., *supra* note 183 at 2062.

<sup>1086</sup> Man *CRA*, *supra* note 616. See page 76 for a description.

recognition, with most being in legislative form.<sup>1087</sup> Importantly, the acts in both Manitoba and Australian jurisdictions do recognize that there is a relationship between the caregiver and their care recipient while also acknowledging the caregiver as someone with their own needs outside of this relationship.<sup>1088</sup>

Consultation with caregivers is an important feature of most of the acts. In Australia nearly all of the acts require consultation with caregivers when developing policy, and several acts require the creation of a carer's advisory council.<sup>1089</sup> The Manitoba Act is weaker in language than some of the Australian Acts in that it does not require but only allows for the appointment of a caregiver advisory committee, although in practice one has been established in the province.<sup>1090</sup> The Manitoba Act also is weaker in language in consultation - even though it requires consultation, this may be with caregivers but could also be with other government agencies or bodies.<sup>1091</sup> Consultation with caregivers should be an important feature of caregiver recognition legislation, and of creating legislation and policies that impact caregivers to ensure that these programs reflect the actual needs of caregivers, and are created in a manner which will be accessible and understandable to caregivers who are generally pressed for time, and have been found not to know about all the programs which are available.<sup>1092</sup> This consultation acknowledges that caregivers have a unique perspective, that they are an important part of the health care system and society, and an important member of the health care team.<sup>1093</sup> The requirement for advisory councils is important because it indicates that carers are important at the higher policy level of the government, not just at the level of health care organizations that are providing the services relevant to caregivers.

Reporting is also a common feature of the caregiver recognition legislation. Australia's Acts have a fairly minimal reporting requirement with organizations involved with services for caregivers having to report what they have done to comply with the Act, but no further

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<sup>1087</sup> Cth CRA, *supra* note 724; NSW CRA, *supra* note 747; Vic CRA, *supra* note 7467 SA CRA, *supra* note 747; Qld CRA, *supra* note 747; WA CRA, *supra* note 747; NT CRA, *supra* note 747; Tas Carer Policy, *supra* note 748; ACT Charter Postcard, *supra* note 749.

<sup>1088</sup> Man CRA, *supra* note 616, Sch.; Cth CRA, *ibid*, Sch 1; NSW CRA, *ibid*, Sch 1; Vic CRA, *ibid* s 11, 12, 14; SA CRA, *ibid*, Sch 1; Qld CRA, *ibid*, Sch; NT CRA, *ibid*, Sch; WA CRA, *ibid*, Sch 1; Tas Carer Policy, *ibid* at 8-9.

<sup>1089</sup> NSW CRA, *ibid*, s 7; SA CRA, *ibid*, s 6; Qld CRA, *ibid*, s 9; NT CRA, *ibid*, s 6; WA CRA, *ibid*, s 6.

<sup>1090</sup> Man CRA, *supra* note 616, s 10(1); Government of Manitoba, Senior and Healthy Aging Secretariat Website, < [www.gov.mb.ca/shas/cgsupport/cac.html](http://www.gov.mb.ca/shas/cgsupport/cac.html) > at Caregiver Advisory Committee.

<sup>1091</sup> Man CRA, *ibid*, s 7.

<sup>1092</sup> BCLI, *supra* note 3 at 61; Smith, It's About Time, *supra* note 302 at 132-133; ABS, Caring in the Community, *supra* note 161; Stockwell-Smith et al., *supra* note 183 at 2062.

<sup>1093</sup> Cth CRA, *supra* note 724, s 3, Sch 1; Man CRA, *supra* note 616 s 2, Sch.

requirements on organizations or government to follow up on this or publish it for the public.<sup>1094</sup> However, the Manitoba act does require the minister write a report regarding caregiver supports and how the government has complied with the act, to be published on a website for the public to access.<sup>1095</sup> These reports have been published, and are good resources for caregivers to see both what supports are available to them, and evidence of the government's attempts to fulfill the goals of the act. This public recognition of the progress, or lack of progress, is also a way through which caregivers and their organizations can lobby for further caregiver supports, although this act does not give any legal avenues to pursue breaches of the act.<sup>1096</sup> Publication of the results, unlike Australia's reporting requirements, could put some pressure on government to comply with the act and further its purposes.

Nova Scotia, while not having a formal caregiver recognition act, does also provide some recognition of the caregiver's contribution to society through providing financial compensation in the form of the Caregiver Benefit, and statements recognizing the contribution within the policy framework.<sup>1097</sup> The financial payment provides a very strong recognition of the caregiver's service to society as a whole through using government funds to support caregivers. This is a very tangible recognition of the caregiver's work and the detriments they face in other aspects of their life, and shows a commitment beyond only recognizing caregivers in words (even if minimally, given the dollar amount of this payment).

Caregiver recognition legislation is important from a relational perspective. First, it is key that most of these acts recognize that a relationship does exist between a caregiver and care recipient. This confirms a central tenet of the importance of relationships to all people within relational theory.<sup>1098</sup> Recognizing the relationship alone will not lead to government action which will aid caregivers and care recipients. Nonetheless, it is a good start for the government to note that a relationship does exist within the context of caregiving. The simple recognition does not overtly note the degree to which this relationship may influence the lack of choice a

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<sup>1094</sup> Cth CRA, *ibid*, s 8; DSS, CRA Guidelines, *supra* note 725; NSW CRA, *supra* note 747 s 8; Vic CRA, *supra* note 747 s 12; SA CRA, *supra* note 747 s 7; Qld CRA, *supra* note 747, s 10; NT CRA, *supra* note 747, s 7; WA CRA, *supra* note 747, s 7; Tas Carer Policy, *supra* note 748 at 11. In reporting, all that the Cth CRA requires are that these groups report annually on what they are doing to comply with the policies (s 8).

<sup>1095</sup> Man CRA, *supra* note 616, s 8.

<sup>1096</sup> Man CRA, *ibid*, s 11.

<sup>1097</sup> Caregiver Benefit Program Policy, *supra* note 609; NS Caregiver Benefit Website, *supra* note 609 – the benefit is currently \$400 per month.

<sup>1098</sup> Nedelsky, *supra* note 317 at 118-119.

caregiver has in providing care work. But, this recognition may pave the way to other supports which may strengthen this relationship.

Second, this recognition of caregivers, formal or otherwise, is important because in Australia it signifies the fact that informal care work is something which is of value to society. In Canada, relational theorists argue that care work is not valued by society, and this devalues the caregiver.<sup>1099</sup> Caregiver recognition in Australia does not compensate caregivers for this valuable service, but it does give face value to the work done by caregivers by noting in formal legislation that this care work is important to the health of citizens and contributes to society. Creating similar legislation in Canada would provide a needed recognition of the importance of this work. However, some practical compensation or greater gender equality for caregivers is needed to demonstrate a practical valuing of this work. Recognizing the value in words alone will not help caregivers achieve more autonomy, because the oppressive circumstances caregivers face such as limited work conditions, lower pay, and the gendered division of care work would still exist. If this recognition legislation does include consultation with caregivers in policies relevant to them, this could be a practical method of achieving increased autonomy because women may be able to push for more carer-friendly policies.

### **Conclusion**

This chapter has compared the government supports in both countries and analyzed them through the lens of relational autonomy. Home and community care is structured similarly in both countries, and fills the gap where informal care work is insufficient. For caregiver supports, Canada and Australia have some areas where supports are similar: respite care is available in both but not enough for caregivers; leaves are similar in both countries, but Australia has more workplace flexibility; and tax relief is similar in both countries. Some supports are greater in Australia than in Canada: direct payments to caregivers are greater in number but not enough for most caregivers if they are not caring full time; retirement income is more robust; community resources and access to information are significantly more in Australia; and caregivers and their value to society are recognized much more through statute. The next chapter lists policy recommendations for future regulatory reform in Canada to better support women in their informal caregiving role in a way which would further women's autonomy.

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<sup>1099</sup> Sherwin & Winsby, *supra* note 18 at 186-186; Nedelsky, *supra* note 317 at 28-29.

## CHAPTER SEVEN: POLICY RECOMMENDATIONS

### *1) Increase the Actual Amount of Formal Home Care for Seniors*

A method of supporting caregivers of the elderly is to increase the actual amount of home care available to Canadian seniors, as well as decreasing the stresses on the formal health care system. Given the reality of the lack of services, and the fact that formal home care only fills in where informal care work leaves off, Canadian seniors are not able to access much formal health care.<sup>1100</sup> This leaves a significant amount of the increasingly medicalized care to informal caregivers.<sup>1101</sup> It would ease the burden of caregivers to transfer some of the more medicalized aspects of care to formal caregivers who are trained, leaving some of the less burdensome and less medical care to family members, such as emotional support and instrumental care such as helping with chores and errands. This type of care would allow caregivers to better balance paid work and care work because they may be able to do this type of care work more easily outside of work hours, reducing the work-care conflict that many caregivers face.

In addition to easing the burden on informal caregivers, increasing the amount of formal home care for seniors would also help ease the burden on the rest of the formal health care system, such as hospitals and residential care. Seniors who may be able to live at home if they had more formal home care have to enter residential care or take up hospital beds.<sup>1102</sup> A study found that 22% of those surveyed entering residential care could have still lived at home, and not having a caregiver was a factor in needing to enter residential care.<sup>1103</sup> Some seniors spend an average of 34 days waiting in hospital for home care when they no longer need hospital care.<sup>1104</sup> These are great burdens on the formal health care system that may be alleviated by adding more home care. The Canadian Institute for Health Information argues that home care is cheaper than hospital and residential care, so seniors could be cared for more optimally within the home where they can still retain some independence.<sup>1105</sup> Jacobs et al. also noted that high-intensity caregivers

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<sup>1100</sup> Best of Care, *supra* note 16 at 9-10, 12, 32; Spencer & Soden, *supra* note 900 at 23-24.

<sup>1101</sup> Armstrong & Kits, *supra* note 6 at 62-65.

<sup>1102</sup> CIHI, Seniors in Transition, *supra* note 524 at 9-11, 17-19.

<sup>1103</sup> *Ibid* at 17-20.

<sup>1104</sup> *Ibid* at 25-26.

<sup>1105</sup> *Ibid* at 27-28, 30.



cost the government \$641 million per year from inability to engage in paid work,<sup>1106</sup> so increasing formal care could allow caregivers to engage more in the paid workforce. Given the fact that inadequate formal home care stresses both informal caregivers who are having to pick up the slack, and the formal health care system which has to spend resources that could be used more effectively elsewhere, increasing home care would be beneficial to many.

## 2) Recognize Caregivers

Canada should create federal and provincial legislation to recognize caregivers. The legislation in Australia provides a strong example for what could occur in Canada. This recognition is important because it acknowledges the contribution unpaid caregivers make to the country, the cost of this work to women, and the role the state and society play in placing this role on women. This legislation should recognize that caregivers possess unique knowledge due to their experience in this health care role. Caregivers should be recognized as members of the caring team of the elder, as they play an important role in communicating and working with the formal health care system as well as providing care work. Legislation should also directly state the value that this care work gives to society as a whole. The needs of caregivers themselves should be explicitly stated as important, apart from the needs of the care recipients. Caregivers face tolls from this care work that have been discussed, and thus are in need of care and other protections to ensure they can perform this care work in the long-term. Recognition is key from a relational autonomy perspective because it values care work, and the interdependency and dependence that is a part of life, and especially in old age.<sup>1107</sup>

Caregiver recognition legislation in Canada should include formal recognition of the relationship between the caregiver and the care recipient. Highlighting the importance of this relationship is key from a relational perspective because under this theory, choices are influenced and constrained by the relationships one is in, and emotional concerns are also a valid and usual aspect of the decision-making process.<sup>1108</sup> This dependency should be considered normal and important in the life course.<sup>1109</sup> Deciding to engage in care work is done within the context of a family or friend relationship, and not a decision made by oneself through a logical assessment of

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<sup>1106</sup> Jacobs et al., *supra* note 1052 at 109.

<sup>1107</sup> Nedelsky, *supra* note 317 at 27-29; Sherwin & Winsby, *supra* note 18 at 185-186.

<sup>1108</sup> Nedelsky, *ibid* at 118-119; Downie & Llewellyn, *supra* note 338 at 200-202.

<sup>1109</sup> Sherwin & Winsby, *supra* note 18 at 185-186.

the situation and facts.<sup>1110</sup> These pre-existing relationships and emotional pressures may be influencing the caregiver in her decisions, restricting the choices which women can make. Caregiver recognition should make explicit note of this relationship and its influence because this needs to be accounted for in programs and policies that are aimed at both the caregiver and the care receiver. Recognizing the relationship can include recognizing caregivers through providing services such as counselling to help maintain this relationship and build the skills to maintain communication.

Using legislation to recognize caregivers can play an important purpose. A full discussion of instrument choice and governance is beyond the scope of this thesis, but some caregiving scholars in both countries have argued for government providing more recognition and supports. Brewer, Nedelsky, and Smith all argue that the government plays a role in creating gender norms for care work and models of employment through the policies they put forward.<sup>1111</sup> Keefe and Rajnovich report that in other countries, governments do use instruments such as payments to show the societal value of care work.<sup>1112</sup> Instrument choice scholars note that legislation and regulation, one of the strongest tools of government, is most commonly used to implement their policy goals, including in the health care arena.<sup>1113</sup> Using such a forceful tool to recognize caregivers would go some way to showing the government supports caregivers symbolically and actually, which could start a movement toward gender norms being more equalized in the area of care work. Given that governments do influence gender norms by their instruments, including legislation, using legislation to recognize caregivers would be using the same tools that disadvantage women to start to move towards valuing them and their care work.

### 3) *Require Consultation with Caregivers*

Government should be required to consult with caregivers when creating legislation and policy that impacts caregivers and programs which are aimed at supporting caregivers. This could be included in legislation such as caregiver recognition acts such as occurs in Australia, or within pre-existing Canadian legislation. Consultation could come in a variety of forms, such as individual caregivers, advisory boards, or carer groups such as Carers Australia. Authors have

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<sup>1110</sup> Sherwin & Winsby, *ibid* at 184; Downie & Llewellyn, *supra* note 338 at 200-202.

<sup>1111</sup> Brewer, *supra* note 105 at 231-232; Nedelsky, *supra* note 317 at 131-132; Smith, Baby with the Bathwater, *supra* note 302 at 701-702.

<sup>1112</sup> Keefe & Rajnovich, *supra* note 268 at 82-84.

<sup>1113</sup> Elias, Hill, & Howlett, *supra* note 250 at 8; Peters & Hoornbeek, *supra* note 251 at 80; Whiteford, *supra* note 251 at 264-265.

argued for consultation for caregivers from several perspectives. Relational autonomy scholar Nedelsky argues that government policy creates unequal care division because most legislators have not experienced performing or receiving this unpaid care work.<sup>1114</sup> Kodar notes that women's groups were key in highlighting the needs of women and their unpaid care work in the policy discussions for pensions in the past.<sup>1115</sup> Having caregivers be a part of the policy creation acknowledges their unique knowledge of the caregiving situation, the personal relationship that others are not privy to, and the caregiver's personal needs. However, the consultation needs to account for a wide range of carers since there is not one singular type of caregiver or situation, although all caregivers may face some similar challenges. Consultation should involve different caregiver situations to better account for needs such as those from rural or urban areas, higher and lower incomes, and recent immigrants.

#### *4) Monitor Commitment to Compliance with Caregiver Programs*

If Canada creates recognition legislation which imposes an obligation on the government to evaluate and create programs to support caregivers, compliance requirements (with this legislation) should go beyond what Australia's legislation does. Governments should have to do more than just state in a report whether they are complying with the legislation – there should be more detail included in who should have to review these reports and oversee ongoing compliance. Legislation should also lay out what will be done to follow up on a lack of adherence. A caregiver advisory board such as exists in some of the caregiver recognition legislation in Australia could be a possible mechanism to review reports and monitor compliance on a more regular basis. Giving caregivers a legal remedy may not be sufficient because caregivers may not have the financial ability to sue individually for breaches of legislation, and there are no concentrated caregiver associations in Canada to fight breaches.<sup>1116</sup>

#### *5) Provide a Comprehensive and Coordinated Range of Financial and Employment Supports*

Canada should create a comprehensive range of financial and employment supports which are designed to work together to provide income and pension sufficiency for women who are engaged in care work. Australia's financial supports can provide a basis for creating reforms in Canada, although the amounts are too low. Canada could create payments for caregivers to support them while they are performing care work and may have a reduced income and ability to

<sup>1114</sup> Nedelsky, *supra* note 317 at 28-29.

<sup>1115</sup> Kodar, Pension and Unpaid Work, *supra* note 268 at 202-203.

<sup>1116</sup> BCLI, *supra* note 3 at 61; Smith, It's About Time, *supra* note 302 at 132-133.

save for retirement. As the direct payments in Australia are mostly aimed at caregivers who cannot engage in paid employment, these direct payments are not enough to ensure all caregivers have a liveable wage. Payments in Canada would need to be a higher amount to ensure economic sufficiency. Financial supports should also address long-term financial security because impacts extend beyond just the time one is caring. For example, financial support while caring is important to ensure a caregiver does not live in poverty during the caregiving years, but if care work ends prior to retirement they may not have sufficient income after if their employment track or retirement savings are impacted.

Financial supports for caregivers should also include promoting retirement sufficiency for caregivers to reduce the financial impact they face so that women can have options for their own care once they reach old age and have money which is their own. The public pension system is likely the easiest method to ensure this sufficiency, as several Canadian authors have argued.<sup>1117</sup> Extending OAS and GIS could be one method which would apply to any Canadian regardless of their ties to paid employment.<sup>1118</sup> CPP should be expanded to compensate for care work – giving caregivers contributions toward their CPP while they have reduced employment income due to care work would be a strong method for providing sufficiency and recognition for caregivers. Relational autonomy authors argue that supporting caregivers and showing that they have value to society are important in recognizing and promoting the importance of dependency and care to a person's self.<sup>1119</sup> Providing pension credits and direct payments to caregivers gives a tangible recognition of the value of care work to society and to those for whom they care. Financial support is important because it goes beyond lip service to recognize a caregiver's value – the government would be giving back to caregivers some of what they contribute to society.

Canada should follow Australia's lead and create government-mandated flexible work accommodations for those who are engaged in unpaid elder care work. Workplace flexibility, from a relational perspective, would be the best method for the government to promote more autonomy for caregivers. Women would be better able to remain in their employment field if they wish to do so if they can alter their work arrangements or hours to fit care work and paid

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<sup>1117</sup> BCLI, *ibid* at 90; Report of the Standing Committee, *supra* note 96 at 6-7, 11-14, 16-17; McDonald, *supra* note 7 at 157-158; Kodar, Pension (In)Securities, *supra* note 68 at 93-94, 96-97; Spencer & Soden, *supra* note 900 at 10-12; Yong, *supra* note 268 at 664-665, 664; Woodman, *supra* note 268 at 135, 138.

<sup>1118</sup> McDonald, *ibid* at 158; Report of the Standing Committee, *ibid* at 11-14; Kodar, Pension (In)Securities, *ibid* at 96-97; BCLI, *ibid* at 90; Spencer & Soden, *ibid* at 12; Yong, *ibid* at 667.

<sup>1119</sup> Sherwin & Winsby, *supra* note 18 at 185-186; Nedelsky, *supra* note 317 at 82-84.

work together, and not have to leave their jobs to care and put themselves at financial risk. However, women should not have to go to court to ensure that this right to flexible work arrangements is provided, as this could be too onerous or costly. Where Canada could improve on Australia's framework is through legislating a negotiation process through which caregivers and their employer can work through disagreements on what flexible work requests can be accommodated within the bounds of the employment context. Australia does have Carers Australia to aid caregivers in working with employers to obtain these flexible arrangements. Having such an organization in Canada would also help caregivers negotiate these processes, although this is not something the government could mandate.

Canada's employment leave scheme, while stronger than Australia's, could still be bolstered to aid caregivers. Having paid leave would provide the strongest of protections for caregivers because women would not lose income if they need to take time off paid work to do care work. Australia's paid sick and care leave is one possible model, but paid leaves in Canada should operate separately for personal sick leave such as that a caregiver would not have to lose paid leave time for her own illnesses if the caregiver takes this paid leave to aid her family members.

Increasing respite care in Canada would help caregivers in many aspects of their personal lives. However, increasing leaves and flexible work arrangements would be of greater importance to caregivers in balancing paid work and care work due to the fact that care work may require a more ongoing method of support. Tax offsets could be bolstered to better help ensure a caregiver has financial sufficiency in her life. Tax offsets should be refundable, as authors have argued, such that low-income caregivers can utilize these.<sup>1120</sup>

Financial and employment supports for caregivers should be reviewed and reformed as a whole to ensure that the system is able to aid caregivers from many different walks of life. This includes caregivers who are in precarious employment and already facing financial difficulties in addition to care work, who are in need of the direct payments and pension supports to ensure they have a livable wage. On the other end, caregivers who are engaged in full-time regular employment may be in more need of flexible work arrangements and leaves such that they can remain in their current jobs. Smith has argued in Australia that the creation of the *FWA* is an important step forward to helping caregivers because reforms do need to address both inequality

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<sup>1120</sup> BCLI, *supra* note 3 at 72-73.

based on gender and inequality based on socio-economic situations.<sup>1121</sup> Reforms as a whole need to address the fact that a male model of working is currently the norm, and create an employment model where caring is integral to the normal employment model, and both men and women do take time away from paid work to do care work.<sup>1122</sup>

Those making changes to the employment legislation need to be cognizant of the fact that law can promote or restrict gender equality and the gendered division of labour.<sup>1123</sup> From a relational perspective, changes to employment law need to address the societal rules that constrain a woman's choices in care work in order to give women more autonomy.<sup>1124</sup> Allowing for financial compensation for caregivers and rules to better allow caregivers to balance paid work and care work would ensure whichever choice a caregiver wants to make, she would have sufficient income. Workplace reform is needed to address that women cannot currently fit their care work into their paid work, and encourage both genders to undertake care work. Care work should not be separated from the employment context as both are important to each other.

#### *6) Provide Caregiver Supports for Emotional and Educational Aspects*

Caregivers should be provided with more emotional support and education to ensure this unpaid care work is sustainable for a longer period of time. Caregivers do deal with significant health conditions, so training on how to manage medical conditions such as Alzheimer's could improve a caregiver's daily care work. Additionally, caregivers should have information on caregiving techniques such as planning and managing care so that caregivers can reduce their workload. Counselling and training have been demonstrated to be beneficial.<sup>1125</sup> Australia's government-provided counselling is a good mechanism for Canada to use because it focuses on the caregiving relationship and caregiving skills. Counselling would address a gap in the government supports in Canada, which are not currently providing any emotional support. The government should also provide diverse forms of respite care which are useable and actually meet the extent of needs of caregivers because this may help reduce their emotional burden. Bolstering caregivers by helping reduce emotional impacts and giving more access to education is particularly salient in the context of the relational nature of care work. Both parties in the relationship may not have had the choices they wanted for care, and emotional supports and

<sup>1121</sup> Smith, FWA, *supra* note 302 at 547-548, 554-555, 561.

<sup>1122</sup> Smith, FWA, *ibid* at 548, 555, 567; Baird, Williamson & Heron, *supra* note 302 at 327-329, 339.

<sup>1123</sup> Smith, Baby with the Bathwater, *supra* note 302 at 701-702.

<sup>1124</sup> Sherwin & Winsby, *supra* note 18 at 184.

<sup>1125</sup> Williams & Owen, *supra* note 194 at 40.

education could reduce some of the friction to make sure this care relationship can continue.

#### 7) Provide Greater and Centralized Caregiver Information on both Supports and Education

Information on education and supports for caregivers in Canada should become more centralized, such as exists in Australia's Carer Gateway. Information and education are tools by which the government can provide services to its citizens,<sup>1126</sup> and information should be utilized more in the case of care work. In Canada, information is currently fragmented onto different websites, and caregivers may not be able to access all the possible information and resources. Australia's Carer Gateway is a strong model for Canada to emulate to ensure caregivers can actually access that which the government provides. However, Canada could go further in its policy to ensure caregivers receive needed information. Health policy should require that health care providers such as doctors and home care assessors also be aware of caregiver supports and education because caregivers and care recipients are in regular contact with these individuals. Doctors may also be most aware of the needs of care recipients and caregivers, and thus be in the best place to know what information to pass on.

#### **Limits of Reform Possibilities**

This thesis has discussed supports for caregivers of the elderly and reform possibilities to better support caregivers in this role. By no means is this meant to exclude the possibility of including other groups of carers, such as mothers of young children, from also benefiting from these potential reforms. These reforms could apply to caregivers of all family members, young and old, given the caring work women do for all family members over their life course, although care for different groups of family is not all the same. This thesis was limited in scope to discussing the specific group of caregivers of the elderly, to bring attention to this growing group of caregivers.

While there may be many benefits of these potential reforms for caregivers in Canada, there are limits to their ability to fully correct the gender imbalances and negative impacts involved in care work. Smith notes that the reforms in Australia have not fully corrected the gendered nature of care work.<sup>1127</sup> In fact, reforms can in some cases reinforce the gendered nature of care work by making it more economical for women to leave paid work and provide

<sup>1126</sup> Howlett, *supra* note 254 at 36; Peters & Hoornbeek, *supra* note 251 at 81-82.

<sup>1127</sup> Smith, *Baby with the Bathwater*, *supra* note 302 at 695-697, 701-702.



care work.<sup>1128</sup> The employment context still favors those who do not have to perform care work and are able to devote all of their time to their careers, which is currently a male model of work.<sup>1129</sup> Caregiver supports alone will not change who society normalizes as the primary caregiver, give parity in employment wages, and remove the stigma of unpaid care work.

Despite the limits of government creating supports for caregivers, this legislation may still play an important role in signalling a respect for women and caregivers. Relational autonomy argues for the need to give value to care work as it is based on a belief that care and relationships are an important part of the self that everyone should experience.<sup>1130</sup> Keefe and Rajnovich also argue that providing supports compensates women as a gender for work that society has foisted upon them and is “...a matter of gender justice.”<sup>1131</sup> The government can also play a role in increasing autonomy.<sup>1132</sup> By providing stronger government supports, the government can show the government’s valuation of care work, and start a societal shift in the gender norms of care work. This can still be a step forward to changing gender norms and gaining parity.

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<sup>1128</sup> Smith, *Baby with the Bathwater*, *ibid* at 689-690, 701-702; Pocock, Charlesworth & Chapman, *supra* note 302 at 608; Keefe & Rajnovich, *supra* note 268 at 83-84.

<sup>1129</sup> Smith, FWA, *supra* note 302 at 547-549; Baird, Williamson & Heron, *supra* note 302 at 328-329; Pocock, Charlesworth & Chapman, *ibid* at 608.

<sup>1130</sup> Nedelsky, *supra* note 317 at 153-155; Sherwin & Winsby, *supra* note 18 at 186-186.

<sup>1131</sup> Keefe & Rajnovich, *supra* note 268 at 84.

<sup>1132</sup> Nedelsky, *supra* note 317 at 65-72, 131-132.

## CHAPTER EIGHT: CONCLUSION

In Canada, there are an increasing number of seniors due to increased longevity and the baby boomer generation entering retirement; these seniors are living longer with functional limitations, chronic illnesses, and other medical conditions which are leading to a greater need for care.<sup>1133</sup> The majority of care for seniors is provided by family members without any financial support.<sup>1134</sup> Women in particular perform more hours and higher intensity care work.<sup>1135</sup> Caregivers experience many impacts from care work such as depression, isolation, exhaustion, increased use of the health care system, and employment impacts such as decreased income, decreased pension entitlements, and changing or leaving jobs.<sup>1136</sup>

My research question is what are the policy implications of the legal treatment of caregivers of the elderly in Canada and Australia and how can this inform law and policy reforms in Canada. To do this, I examined the legislation and policy governing the supports for informal caregivers of the elderly in both countries. I examined Canadian supports in the provinces of BC and Ontario, which included information, respite care, some short employment leaves, and a longer leave for caregivers whose relative has a terminal illness.<sup>1137</sup> There are some other benefits outside of these provinces such as the Caregiver Recognition Act in Manitoba, direct payments for caregivers in Nova Scotia, and federal supports such as tax credits and the EI Compassionate Care Benefit.<sup>1138</sup> Australia has supports such as carer recognition legislations, government-provided information, respite, carer payments, employment leaves, flexible work arrangements, tax relief, and carer associations.<sup>1139</sup> I compared these supports in the analysis chapter and found that some programs were similar such as respite care, tax relief, and

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<sup>1133</sup> BCLI, *supra* note 3 at 16-17; Smith, Elder Care, *supra* note 4 at 356-357.

<sup>1134</sup> Armstrong & Kits, *supra* note 6 at 48-53; 64.

<sup>1135</sup> Smith, Elder Care, *supra* note 4 at 360-361.

<sup>1136</sup> Lee, *supra* note 7 at 30-32; McDonald, *supra* note 7 at 149-150; Alan, Atalay & Crossley, *supra* note 7 at 97, 111.

<sup>1137</sup> See for example: BC H&CC Website, *supra* note 16; Fraser Health Handbook, *supra* note 529; BC ESA, *supra* note 550; Seniors' Secretariat Guide, *supra* note 21; Ont Respite Care Website, *supra* note 565; Ont ESA, *supra* note 577.

<sup>1138</sup> See for example: Man CRA, *supra* note 616; NS Caregiver Benefit Website, *supra* note 609; EIA, *supra* note 624; CCC Website, *supra* note 637.

<sup>1139</sup> See for example: Cth CRA, *supra* note 724; Carer Gateway Website, *supra* note 722; Health Direct Website, *supra* note 760; Carer Payments Website, *supra* note 759; Carer Leaves Website, *supra* note 832; FWA, *supra* note 833; Cth ITAA, *supra* note 869; Carers Australia Website, *supra* note 876; Carers ACT Website, *supra* note 882.

workplace leaves which while similar were also insufficient in their current form to support caregivers. Some caregiver supports were stronger in Australia such as direct payments, retirement income sufficiency, community resources, access to information, and caregiver recognition, and these could be reform potentials to consider in Canada.

Relational autonomy theory was used to examine how well these supports enabled caregivers and the care recipients to maintain their relationships, while allowing for maximal autonomy in their care work decisions and other life decisions. Reforms are needed to better support informal caregivers of the elderly. This includes increasing formal care to take some pressure off informal caregivers and other parts of the formal system, giving caregivers access to more education and emotional support to make care work more sustainable, recognizing the value of this care work, and creating economic supports in a comprehensive manner to make sure that caregivers have sufficient income across the life course.

This thesis expands on the literature I have discussed in a few ways. The BCLI study paper examined supports for caregivers of a wide range of family caregivers and focused on caregivers who were in paid employment.<sup>1140</sup> This thesis focused just on caregivers of the elderly, but examined caregivers who were both in paid employment and who were not. The BCLI report, while describing some possible reforms which have been used in other countries or suggested by other researchers, did not give any specific recommendations for reform.<sup>1141</sup> The wider Canadian literature on unpaid care work has focused on how pensions could be reformed to better help women who have to take time out of paid work to care for family members and are often in precarious employment and thus have reduced pension entitlement.<sup>1142</sup> This thesis did look at pension reform, but also examined other employment supports which could be combined with bolstering the pension system to give women stronger financial sufficiency. Education supports and caregiver recognition have not been examined very much in the literature, and this thesis examined the importance of giving caregivers information on how to care, giving easy access to resources to help them care for the caregiver and themselves, and the value to caregivers both in words and in reality of recognizing their work and its contribution to society.

The policy recommendations I have made would be a step forward to changing society's views of care work as a role for women within the home which should be separate from the

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<sup>1140</sup> BCLI, *supra* note 3.

<sup>1141</sup> BCLI, *ibid.*

<sup>1142</sup> Kodar, Pension (In)Securities, *supra* note 68; Woodman, *supra* note 268; Yong, *supra* note 268.

public and employment realm. If these changes are all made, they would help women not be penalized for the fact that they have to care for their relatives, by having reduced incomes and the emotional and physical burdens that accompany this care work. However, the reality is that these reforms are not likely to all be implemented. There would be a cost associated with these reforms, especially more onerous ones such as increasing formal care and giving caregivers direct payments for their care work. The cost and task may be large, but that does not mean that some of these reforms should not be considered. While reforms may not be successful at removing all of the impacts of informal care work if they are made piecemeal, even a small start at giving informal caregivers of the elderly more support is a start toward recognizing their care work and changing the impacts of this role. Informal caregivers play a crucial role caring for seniors. This care work should be valued, recognized, and supported within all aspects of society.

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**APPENDIX A:  
LAW AND POLICY SUMMARY CHART**

	<b>Home Care</b>
<b>Australia</b>	<ul style="list-style-type: none"> <li>• Available Services:               <ul style="list-style-type: none"> <li>○ In-home Care: includes nursing, physiotherapy, personal care, home cleaning and maintenance, shopping, cooking, and counselling</li> <li>○ Aged Care Homes: residences for those who need personal and medical care continuously</li> <li>○ Transition Care: health care services for up to 12 weeks after discharge from hospital</li> </ul> </li> <li>• Eligibility Requirements:               <ul style="list-style-type: none"> <li>○ Live at home, and need assistance living at home</li> <li>○ For Commonwealth Home Support Program, also be at least 65 years of age</li> </ul> </li> </ul> <p><i>(ACA, note 160; DSS, Guide to Aged Care Law, note 670; My Aged Care Website, note 159; DSS, 5 Steps to HCP, note 687)</i></p>
<b>British Columbia</b>	<ul style="list-style-type: none"> <li>• Available Services:               <ul style="list-style-type: none"> <li>○ Home Care includes nursing, rehabilitation, personal care, adult day services, and day programs</li> <li>○ Assisted Living is a residence for those that need some help with daily tasks but can still make decisions for themselves</li> <li>○ Residential Care is a facility where clients can receive nursing care, meals, daily care, and recreation</li> </ul> </li> <li>• Eligibility Requirements:               <ul style="list-style-type: none"> <li>○ Need assistance to stay in home, do not have friends and family available to care, care can be provided safely, are adequate public resources</li> <li>○ Are client fees for services</li> </ul> </li> </ul> <p><i>(BC H&amp;CC Website, note 436; BC H&amp;CC Policy Manual, note 16; Best of Care, note 16)</i></p>
<b>Ontario</b>	<ul style="list-style-type: none"> <li>• Available Services:               <ul style="list-style-type: none"> <li>○ Home Care includes nursing, rehabilitation, personal care, housekeeping, and respite care</li> <li>○ Long term care homes provide assistance with daily tasks and nursing</li> </ul> </li> <li>• Eligibility Requirements:               <ul style="list-style-type: none"> <li>○ Have Ontario health insurance, care can be provided safely, and the services must be needed for the care recipient to remain in the home</li> <li>○ No fees for these services</li> </ul> </li> </ul> <p><i>(O Reg 386/99, note 486; Ont H&amp;CC Website, note 20; CCAC Policy Manual, note 479; MOHLTC CCAC Website, note 480; Seniors' Secretariat Guide, note 21)</i></p>

	<b>Respite Care</b>
<b>Australia</b>	<ul style="list-style-type: none"> <li>• Community respite can take place in the home, or in a day center for one day</li> <li>• Residential respite <ul style="list-style-type: none"> <li>○ Provides care for multiple days in an aged care home for those who need a high level of care or a longer break, up to 63 days per year</li> <li>○ Client rate of up to A\$49.25 per day</li> </ul> </li> </ul> <p><i>(My Aged Care Website, note 159; ACA, note 160; Carer Gateway Website, note 722; Health Direct Website, note 760)</i></p>
<b>British Columbia</b>	<ul style="list-style-type: none"> <li>• Types of Respite Care: in-home care, adult day programs, or residential respite care</li> <li>• Eligibility: must meet criteria for home care, and caregiver must need a break</li> <li>• Client rate of \$33 per day for residential respite</li> </ul> <p><i>(BC H&amp;CC Website, note 436)</i></p>
<b>Ontario</b>	<ul style="list-style-type: none"> <li>• In-home respite care: <ul style="list-style-type: none"> <li>○ Care worker comes into the home for a portion of the day</li> <li>○ No client fee</li> </ul> </li> <li>• Long-term respite care: <ul style="list-style-type: none"> <li>○ Provided in a long-term care home for up to 60 days at a time</li> <li>○ A maximum of 90 days of respite per year</li> <li>○ Client fee of \$36.34 per day</li> </ul> </li> </ul> <p><i>(Ont Respite Care Website, note 565)</i></p>

	<b>Direct Payments to Caregivers</b>
<b>Australia</b>	<ul style="list-style-type: none"> <li>• Carer Allowance <ul style="list-style-type: none"> <li>○ Amount <ul style="list-style-type: none"> <li>▪ A\$63.55 per week per care recipient</li> </ul> </li> <li>○ Eligibility <ul style="list-style-type: none"> <li>▪ Carer must provide care every day to a family member</li> <li>▪ Care recipient must have a medical condition, a disability or be frail elderly, and have an assessment</li> <li>▪ no income or asset maximums, carers can work full time</li> </ul> </li> <li>○ Interruptions <ul style="list-style-type: none"> <li>▪ Can take up to 63 days off per year from care work</li> </ul> </li> </ul> </li> <li>• Carer Payment <ul style="list-style-type: none"> <li>○ Amount <ul style="list-style-type: none"> <li>▪ A\$894.40 per two weeks for single person, A\$1348.40 for a couple</li> </ul> </li> <li>○ Eligibility <ul style="list-style-type: none"> <li>▪ Carer must provide continuous care for at least 6 months</li> <li>▪ Care recipient must have disability or medical condition, have an assessment, and have the medical condition for at least 6 months</li> <li>▪ Income and asset test for the carer and care recipient</li> <li>▪ Cannot work or study for more than 25 hours per week</li> <li>▪ Any income reduces the amount of the payment</li> </ul> </li> <li>○ Interruptions <ul style="list-style-type: none"> <li>▪ Can take up to 63 days off per year from care work</li> </ul> </li> </ul> </li> <li>• Carer Supplement <ul style="list-style-type: none"> <li>○ Amount: A\$600 per year</li> <li>○ Intended to help with out of pocket care costs</li> <li>○ Get supplement if receiving Carer Allowance, Carer Payment, or other specified payments</li> </ul> </li> <li>• Payments Upon Retirement <ul style="list-style-type: none"> <li>○ Once caregiver has reached 65, they can keep the Carer Payment or take the Age Pension</li> <li>○ Age Pension is the same amount as the Carer Payment</li> </ul> </li> </ul> <p><i>(SSA, note 793; Carer Payments Website, note 759)</i></p>
<b>British Columbia</b>	<ul style="list-style-type: none"> <li>• Choice in Supports for Independent Living Program Description: <ul style="list-style-type: none"> <li>○ Care recipients can be given funds to find and manage their own care, including paying family</li> </ul> </li> </ul>

	<p>members</p> <ul style="list-style-type: none"> <li>• Eligibility: <ul style="list-style-type: none"> <li>○ Care recipient must be able to manage own care</li> </ul> </li> <li>• Requirements: <ul style="list-style-type: none"> <li>○ care recipient must find, train, and manage caregivers</li> <li>○ immediate family members can only be paid if no other caregivers are available, the risks are manageable, and respite care is part of the care plan</li> </ul> </li> </ul> <p><i>(BC H&amp;CC Website, note 436; BC H&amp;CC Policy Manual, note 16; Best of Care, note 16)</i></p>
<b>Ontario</b>	<ul style="list-style-type: none"> <li>• None</li> </ul>
<b>Nova Scotia</b>	<ul style="list-style-type: none"> <li>• Caregiver Benefit Program Amount: <ul style="list-style-type: none"> <li>○ \$400 per month</li> </ul> </li> <li>• Eligibility: <ul style="list-style-type: none"> <li>○ Caregiver must be 19 years or older, a resident of Nova Scotia, have Nova Scotia health coverage, provide at least 20 hours of care per week, and not be paid to provide care</li> <li>○ Care recipient must be a resident of Nova Scotia, have Nova Scotia health coverage, be at least 19 years of age, require a high level of care, and have a low income</li> </ul> </li> <li>• Interruptions: <ul style="list-style-type: none"> <li>○ Payments continue if care interrupted for less than a month, for circumstances such as being on vacation or in hospital</li> </ul> </li> </ul> <p><i>(Caregiver Benefit Program Policy, note 609; NS Caregiver Benefit Website, note 609)</i></p>

<b>Workplace Leaves</b>	
<b>Australia</b>	<ul style="list-style-type: none"> <li>• Sick and Carer's Leave <ul style="list-style-type: none"> <li>○ Amount: 10 days per year; does carry over into the next year</li> <li>○ Care recipient: must be immediate family member, experiencing an illness or emergency</li> <li>○ Pay: ordinary wage</li> <li>○ To go on leave: notify employer when possible, and give reasonable evidence if asked</li> <li>○ Employment type: available for full-time or part-time employees, accrued during work year, pro-rated for part-time employees</li> </ul> </li> <li>• Unpaid Carers Leave <ul style="list-style-type: none"> <li>○ Amount: 2 days per illness, after using up sick and carer's leave; does not carry over</li> <li>○ Pay: unpaid</li> <li>○ Employment type: available for full-time, part-time, or casual employees</li> <li>○ Protection: cannot be penalized for taking leave</li> </ul> </li> <li>• Compassionate Leave <ul style="list-style-type: none"> <li>○ Amount: 2 days per illness; does not carry over</li> <li>○ Care recipient: must be an immediate family member who is at risk of dying or has died</li> <li>○ Pay: ordinary wage</li> <li>○ To go on leave: notify employer when possible, and give reasonable evidence if asked</li> <li>○ Employment Type: any employment type, including casual</li> </ul> </li> </ul> <p><i>(FWA, note 833; Carer Leaves Website, note 832)</i></p>
<b>British Columbia</b>	<ul style="list-style-type: none"> <li>• Family Responsibility Leave <ul style="list-style-type: none"> <li>○ Amount: 5 days per year, does not carry over</li> <li>○ Care recipient: must be immediate family member or live with employee as family</li> <li>○ Protection: cannot be fired, cannot have employment changed, requires benefits to continue</li> </ul> </li> <li>• Compassionate Care Leave <ul style="list-style-type: none"> <li>○ Amount: 8 weeks within 26 week period, taken in 1 week increments, does not carry over</li> <li>○ Care recipient: must be at risk of dying within 26 weeks, can be immediate family or anyone considered to be like a close relative</li> <li>○ To go on leave: notify employer when possible, and provide medical certificate</li> <li>○ Protection: cannot be fired, cannot have employment changed, benefits continue</li> </ul> </li> </ul> <p><i>(BC ESA, note 550; BC ESA Interpretation Guidelines, note 549; Compassionate Care Leave Regulation, note 559)</i></p>
<b>Ontario</b>	<ul style="list-style-type: none"> <li>• Family Medical Leave <ul style="list-style-type: none"> <li>○ Amount: up to 8 weeks in a 26 week period, taken in 1 week increments, can be shared between</li> </ul> </li> </ul>

	<p>family members</p> <ul style="list-style-type: none"> <li>○ Care recipient: must be at risk of dying within 26 weeks, can be immediate family member or any one considered to be family</li> <li>○ Types of care: physical care, emotional care, or managing care</li> <li>○ To go on leave: notify employer in writing when possible, and provide medical certificate</li> <li>○ Protection: cannot be fired, benefits continue when on leave</li> </ul> <ul style="list-style-type: none"> <li>● Family Caregiver Leave <ul style="list-style-type: none"> <li>○ Amount: up to 8 weeks per calendar year</li> <li>○ Care recipient: must have serious medical condition, be a close family member</li> <li>○ Types of care: physical care, emotional care, or managing care</li> <li>○ To go on leave: notify employer in writing when possible, and provide medical certificate</li> <li>○ Protection: cannot be fired, benefits continue when on leave</li> </ul> </li> <li>● Personal Emergency Leave <ul style="list-style-type: none"> <li>○ Amount: up to 10 days per calendar year, taken in 1 day increments</li> <li>○ Care recipient: have an illness, medical emergency, or urgent matter; must be a close relative or other person dependant on caregiver</li> <li>○ Eligibility: must work for employer with at least 50 employees working at all locations</li> <li>○ To go on leave: must inform employer when possible</li> <li>○ Protection: cannot be fired, benefits continue when on leave</li> </ul> </li> </ul> <p><i>(Ont ESA, note 577; Ont ESA Guide, note 579; O Reg 476/06)</i></p>
<b>Canada (Federal)</b>	<ul style="list-style-type: none"> <li>● Compassionate Care Benefit <ul style="list-style-type: none"> <li>○ Benefit is a payment through EI for caregivers who have missed work to care for a dying relative</li> <li>○ Amount: 26 weeks collectively per care recipient, which can be split between family members</li> <li>○ Dollar value: 55% of average insurable earnings, to a maximum of \$547 per week</li> <li>○ Care recipient: must be at risk of dying within 26 weeks, be a family member or someone considered to be family</li> <li>○ Types of care: physical care, emotional care, or managing care</li> <li>○ To go on leave: Obtain and submit medical certificate when possible, meet general EI eligibility</li> </ul> </li> </ul> <p><i>(EIA, note 624; EI CC Website, note 623; SOR/96-332, note 626)</i></p>



	<b>Workplace Flexibility</b>
<b>Australia</b>	<ul style="list-style-type: none"> <li>• Can request to have work arrangements altered to balance paid work and care work</li> <li>• Care recipient: must be caring for a parent or someone with disability</li> <li>• Employment type: Full-time or part-time employees who have worked for an employer at least 12 months for a regular period</li> <li>• How to request: request changes in writing, employer respond within 21 days</li> <li>• Grounds for refusal: employers can only refuse for reasonable business grounds</li> </ul> <p><i>(FWA, note 825; Flexible Work Arrangements Website, note 852)</i></p>
<b>Canada</b>	<ul style="list-style-type: none"> <li>• Canadian Human Rights Commission Guide: <ul style="list-style-type: none"> <li>○ Guide on how employers can help employees balance paid work and care work</li> <li>○ Employer need not accommodate if will cause undue hardship, no criteria for hardship</li> <li>○ Caregiver must prove there is no other option for care than to accommodate, that they have tried to make other arrangements, and that they have no choice but to perform care work</li> </ul> </li> </ul> <p><i>(CHRC Guide, note 645)</i></p>

	<b>Tax Relief</b>
<b>Australia</b>	<ul style="list-style-type: none"> <li>• Dependant (Invalid and Invalid Carer) Tax Offset: <ul style="list-style-type: none"> <li>○ Non-refundable credit</li> </ul> </li> <li>• Eligibility: <ul style="list-style-type: none"> <li>○ Maintain a person with disability, or maintain carer of person with disability</li> <li>○ Income tests for claimant, and dependent or carer</li> <li>○ No hour of care requirement</li> </ul> </li> </ul> <p><i>(Cth ITAA, note 869; Carer Tax Offset Website, note 869)</i></p>
<b>Canada (Federal)</b>	<ul style="list-style-type: none"> <li>• Canada Caregiver Credit: <ul style="list-style-type: none"> <li>○ Non-refundable credit</li> <li>○ An additional amount received on top of other care related tax credit, such as spouse or common law partner credit, or other eligible adult dependent credit</li> </ul> </li> <li>• Eligibility: <ul style="list-style-type: none"> <li>○ Caring for close family member who has an impairment and is dependent on the caregiver</li> <li>○ No hour of care requirements</li> <li>○ Must obtain a medical certificate</li> </ul> </li> </ul> <p><i>(ITA, note 637; CCC Website, note 637; BCLI, note 3)</i></p>

<b>Caregiver Recognition Legislation</b>	
<b>Australia</b>	<ul style="list-style-type: none"> <li>• Commonwealth Carer Recognition Act Features: <ul style="list-style-type: none"> <li>○ Requires government agencies to follow the Act, develop policies to help employee caregivers</li> <li>○ Agencies must report how they are complying with act</li> <li>○ Does not create a legal obligation</li> <li>○ Sets out statement for carers, including recognizing carers as having their own needs, recognizing the relationship between caregiver and care recipient, and recognizing the caregiver as a health care partner</li> </ul> </li> <li>• Most states and territories have their own carer recognition acts, with the exception of Tasmania which was a Carer Policy and Australian Capital Territory which has a Carers Charter <i>(Cth CRA, note 724; DSS, CRA Guidelines, note 725; NSW CRA, note 747; Vic CRA, note 747; SA CRA, note 747; Qld CRA, note 747; WA CRA, note 747; NT CRA, note 747; Tas Carer Policy, note 748; ACT Charter Postcard, note 749)</i></li> </ul>
<b>British Columbia</b>	<ul style="list-style-type: none"> <li>• None</li> </ul>
<b>Ontario</b>	<ul style="list-style-type: none"> <li>• None</li> </ul>
<b>Manitoba</b>	<ul style="list-style-type: none"> <li>• Manitoba Caregiver Recognition Act Features: <ul style="list-style-type: none"> <li>○ Creates Caregiver Advisory Committee</li> <li>○ Minister must consult with caregivers</li> <li>○ Minister must report how government is complying with the Act</li> <li>○ Contains 8 principles, including recognizing the relationship between caregiver and care recipient, recognizing the value of care work, and recognizing the need to support caregivers</li> </ul> </li> </ul> <p><i>(Man CRA, note 616)</i></p>

	<b>Community Resources</b>
<b>Australia</b>	<ul style="list-style-type: none"> <li>• Carers Australia <ul style="list-style-type: none"> <li>○ Nationwide organization representing carers, advocating for carers, and providing services to carers</li> <li>○ Carer organizations exist in each state and territory</li> <li>○ Represent caregivers when government is consulting with carers, and lobbies for increased carer services and supports</li> <li>○ Services to caregivers include information, counselling, support groups, education, and respite</li> </ul> </li> </ul> <p><i>(Carers Australia Website, note 876; Carers ACT Website, note 882)</i></p>
<b>Canada</b>	<ul style="list-style-type: none"> <li>• Community Organizations and Support Groups: <ul style="list-style-type: none"> <li>○ The Family Caregiver: caregivers sharing information and resources</li> <li>○ The Caregiver Exchange: caregivers sharing information and resources</li> <li>○ Family Caregivers of British Columbia: educational materials, support groups, phone lines</li> <li>○ United Way of Lower Mainland: educational materials</li> <li>○ Ontario Caregiver Coalition: advocating for caregiver supports, providing caregiver resources</li> </ul> </li> </ul> <p><i>(The Family Caregiver, note 649; The Caregiver Exchange, note 649; Family Caregivers of BC, note 650; United Way Handbook, note 650; Ontario Caregiver Coalition, note 651)</i></p>

	<b>Government-Provided Information</b>
<b>Australia</b>	<ul style="list-style-type: none"> <li>• Commonwealth Government Information: <ul style="list-style-type: none"> <li>○ Department of Human Services Website: information on carer payments</li> <li>○ Health Direct Website: information on how to care, links to counselling and support groups</li> <li>○ My Aged Care Website: information on accessing home care and carer supports, tips on caring for seniors with specific health conditions</li> <li>○ Carer Gateway website: comprehensive website for giving information and resources for caregivers, including information phone line, factual information on caring, information for when care work has ended, and specific sections for subgroups of carers</li> </ul> </li> </ul> <p><i>(Carer Payments Website, note 759; Health Direct Website, note 760; My Aged Care Website, note 159; Carer Gateway Website, note 722)</i></p>
<b>British Columbia</b>	<ul style="list-style-type: none"> <li>• Provincial Government Information: <ul style="list-style-type: none"> <li>○ Province of BC Website: senior section has information on informal care</li> <li>○ HealthLinkBC Website: tips for caregivers</li> </ul> </li> <li>• Health Authority Information: <ul style="list-style-type: none"> <li>○ Fraser Health Authority has a printed handbook for caregivers</li> </ul> </li> </ul> <p><i>(Caring for Seniors Website, note 527; HealthLinkBC Website, note 528; Fraser Health Handbook, note 529)</i></p>
<b>Ontario</b>	<ul style="list-style-type: none"> <li>• Provincial Government Information: <ul style="list-style-type: none"> <li>○ Temporary Respite Care for Caregivers website: information on respite care</li> <li>○ Home and Community Care website: detailed information on home care applications</li> <li>○ Ontario Seniors' Secretariat Guide: information on home care, caregiver supports, and community resources</li> </ul> </li> </ul> <p><i>(Ont Respite Care Website, note 565; Ont H&amp;CC Website, note 20; Seniors' Secretariat Guide, note 21)</i></p>