

The Graying State: Elder Care Policy in Canada

The central argument of this paper is that although the Canadian state remains committed to ensuring that veterans are provided with programs and services to meet their changing needs, the same cannot be said of the rest of Canada's elderly population who have also made significant contributions to Canadian society. What is commonly termed the 'crisis in elder care' highlights the issue of responsibility of caring for Canada's growing elderly population (Cancian and Oliker, 2000, p. 69). There may be more demand for elder care than the current pattern of caregiving can provide, and there are fewer options for increasing informal care, however, this is not necessarily an indication of unsupportable demands for care. This paper begins with an examination of the public/private divide, social reproduction, and the distinction between an ethic of care and one of justice. This discussion of key concepts from feminist social theory is important in analyzing the 'care deficit' for elderly Canadians. Secondly, the paper highlights that Canada is about to have a disproportionate number of elderly and explains how this affects elder care recipients and informal caregivers. Next, the paper explores the policy challenges presented by Canada's aging population with emphasis on the influence of the neo-liberal market on social policy making in Canada. On this basis, I advance a social policy model based on a national home-care program called *The Veterans Independence Program* (VIP) that provides care for some of Canada's elderly so that they can remain independent, healthy and living in their own homes. I argue that in efforts to rectify the care imbalances and uncertainties experienced by many of Canada's elderly, a positive amendment would be to extend the VIP home care benefits to all elderly Canadians. This would offer a future where senior citizens are taken care of. This model can/should be applied to all Canadian senior citizens (V.A.C. 4). The final section of this paper considers how the pursuit of alternatives requires an active rather than a retreating state presence in the development of social policy, how the discourse of elder care should be reframed to guarantee access to basic levels of specified services for all elderly Canadian citizens, and how the costs of those services could be more equitably distributed.

Theorizing Care

This paper explores social reproduction, the public/private divide, and the distinction between an ethic of care and one of justice because they are important concepts in undertaking a feminist political economy approach to care policy. These theories contribute to the empirical analysis of this paper because they provide concepts through which to position the Canadian state's social policy decision making, and to frame proposals to reform elder care social policy.

The relationship between the production of goods in the formal economy (the public sphere), and the reproduction of labor taking place in the family (the private sphere) can be explained using the term 'social reproduction.' This term refers to daily and intergenerational reproduction, and the "training and development of skills, the continued well being of the worker for the labor process, and the general standard of living, education and health sustained in society" (Clarke, 2000, p. 137). 'Social reproduction' represents a defining concept in feminist political economy, (Vosko, 2002, p. 51) and can be explained as the synchronizing of political, economic, and domestic sectors (Elson, 1998). While labor is a key factor in the production process, it is usually re-produced and maintained in

private households, mainly by women, and managed by the state through social policies (Fudge and Vosko, 2003, p. 185). There is “a substantial body of feminist literature that has demonstrated the extent to which liberalism relies on the care and social reproduction carried out in the private realm of the home to sustain the formal, rule-governed, and disembodied public realm” (Harder, 2007, p. 175).

It is important to consider changes in the relationship between production and reproduction, and how these are manifested through changes in state policies (Porter, 2003, p. 26). Currently a new series of contradictions is being generated between an economy that is increasingly reliant on women’s paid labor and a state that continues to rely on women’s unpaid work in the home (Porter, 2003, p. 241). While women’s formal equality demands for the right to enter the public sphere of paid work have largely been met, substantive inequalities remain, and in the case of caregiving, both paid and unpaid, they may have deepened (Porter, 2003, p. 241).

In the private realm of the home, women continue to provide a plethora of unpaid work, including care work such as eldercare (Porter, 2003, p. 27). Consequently, this model places “excessive pressure on families, and given women’s role within the home, on women in particular in terms of being able both to meet financial needs, and look after domestic concerns” (Porter, 2003, p. 241). Solutions to the tension between women’s productive and reproductive responsibilities have resulted in an overemphasis on market competitiveness, a de-linking of production and reproduction, and a lack of attention to social reproduction issues (Porter, 2003, p. 241). The caregiver leave program is an example of this, illuminating how an individual’s employment earnings are used to support temporary absence from the workforce through *Employment Insurance* as opposed to state established elder care services. Therefore, “the consideration of alternative ways of organizing the relationship between households, work, and the state, as well as alternative ways of having voices from all sectors heard remains one of the central challenges and priorities of the twenty-first century” (Porter, 2003, p. 241).

Liberal states were originally understood, and have been repeatedly remodeled through what Walzer (1984) termed ‘the art of separation’ (Brodie, 1997, p. 228). “Early liberal theorists sought to reconfigure feudal society, which rested on impositional claims about natural hierarchies, interdependencies and the organic whole by recasting a ‘world of walls’” (Brodie, 1997, p. 228). A line was drawn between the public sphere and the private sphere where the state, bounded by a social contract, did not ‘interfere,’ and where market relations had no influence in the market or in the home (Walzer, 1984, p. 315; Brodie, 1997, p. 228).

“Classic liberal discourse prescribed and then materialized in the recognition of metaphorical, economic and political space” (Brodie, 1997, p. 228). It presented a new governing philosophy that outlined what was ‘natural’ and ‘universal,’ what was included/excluded from the political agenda, and defined the public sphere of liberal-democratic politics to the capitalist market, and to the private sphere (Brodie, 1997, p. 228). “It told the story of a natural, and, therefore, politically uncontestable, complementarity among social spaces, social relations and political actors, as well as between social institutions and social functions” (Brodie, 1997, p. 228). This new liberal order depended on keeping these spheres separated, at least at the level of ‘perceived reality’ (Brodie, 1995, p. 29).

It should be noted that whether a problem is deemed to be public or private is a matter of politics and the prevailing ‘mentality’ of government. Thus, a person’s difficulties in coping with care needs can be perceived and treated as either a private trouble or a public issue (Mills, 1959). Care could be framed as a public issue; however, the contemporary politics of neo-liberalism actively resists conceiving of care needs in a substantively public way. Instead care is perceived as a private trouble; a problem of the individual for which he/she is held responsible (Connidis, 2001). Private troubles are “the problems of individuals for which they are typically held responsible” (Connidis, 2001, p. 251). Much of the explicit treatment of situations as private troubles surrounds responsibility for solving problems (Connidis, 2001, p. 251). Holding individuals accountable for solving their problems can have the effect of “blaming them for their problems, thereby abdicating society of the responsibility for providing solutions” (Ryan, 1971).

The caring required to sustain our lives is commonly regulated/situated in the private sphere. As a result, caregiving is not generally recognized as an important part of citizenship (Hankivsky, 2004, p. 110). Rather, caregiving is commonly seen as the *natural* responsibility of ‘second-class citizens,’ otherwise known as women, and has not been prioritized as part of *normal* social participation despite its permeation of our lives (Hankivsky, 2004, p. 110). By disregarding the power at work in formulating a gendered division of labor and ‘naturalizing’ care as inherently feminine, the state and broader social forces evade prioritizing care on the public agenda.

When problems are treated as public issues, society accepts some responsibility for providing solutions (Connidis, 2001, p. 251). This means that when social policies are developed to support the care needs of Canada’s elderly, there is evidence of treating problems as public issues (Connidis, 2001, p. 252). “However gendered, the liberal-progressivist paradigm of the postwar years held that the national community was responsible for the well-being of its individual members” (Brodie, 1997, p. 234). This postwar ideal of social citizenship is now overshadowed by the current neo-liberal state (Brodie, 1997, p. 234). Canada’s neo-liberal state is cutting back on publicly funded programs and transferring an increasing proportion of caregiving responsibilities to families (Gerstel and Gallagher, 1994). We are in the midst of a “process whereby the public is displaced either to the market or the home, and the unpaid caring work of women” (Brodie, 1997, p. 235). This process is sometimes referred to as ‘reprivatization,’ a term which fosters the illusion that public goods and services are being returned to somewhere where they ‘naturally’ belong (Brodie, 1997, p. 235).

Because of the private “wall” surrounding family work, women’s care of the elderly is invisible, undervalued, and lonely (Olsen, 2003, p. 7). Most seniors were/are cared for invisibly by the women of their families (Jenson, 2002, p. 74). Family members are seen to fulfill *natural* commitments to relatives in need (Aronson and Neysmith, 2003, p. 98). As a result, women’s unpaid care work comes into public view only when it breaks down or threatens to do so (Aronson and Neysmith, 2003, p. 98). It has become the responsibility of families to look after their own, and it is in the interests of the state to make sure that they do (Brodie, 1997, p. 236). Consequently, “all of these shifts reinforce an unequal gender order, and place greater stress on the unpaid work of women” (Brodie, 1997, p. 236).

Critical observers of these processes call attention to the politically constituted character of the line dividing family and public responsibility for the care of Canada's elderly (Aronson and Neysmith, 2003, p. 98). "The public-domestic divide is not, as classic liberalism would have it, the line marking where politics ends and nature begins" (Brodie, 1997, p. 230). Rather than a natural unfolding of family care and unobtrusive state interventions, the line is revealed as a shifting division determined by political and economic interests (Aronson and Neysmith, 2003, p. 98). "It is a contested cultural construction, saturated with impositional claims and gendered codings" (Brodie, 1997, p. 230).

The public sphere has been labeled as 'the other' of the market and of the home, "an other which is subject to different rules and distributional practices" (Brodie, 1997, p. 230). This concept is delivered in neo-classical economic theory as the distinction between public and private goods, although what has been determined to fall into either category is a product of politics and is never static (Brodie, 1997, p. 230). It should be noted that different state forms rest on varied negotiations of the public sphere and the private sphere, which flavor public policies (Brodie, 1997, p. 230).

Cost-cutting in elder care pushes caring work out of the public domain and onto the already overburdened shoulders of family carers (Aronson and Neysmith, 2003, p. 98). Cuts in public provision, such as early hospital discharges, reduced nursing home beds, and cuts in home care result in a shifting of care work onto families, demonstrating how the neo-liberal state reorganizes the labor process to make use of 'free' service labor (Aronson and Neysmith, 2003, p. 98). Justified as cost reductions in public accounting, such cuts represent cost increases for family carers (Aronson and Neysmith, 2003, p. 98). It should however be understood that neo-liberalism is more than a strategy for economic growth (Brodie, 1997, p. 235). Neo-liberal discourse highlights the power of the market over, and inside the state, and thereby, "atrophies the public, closes political spaces, and further marginalizes the already marginalized" (Brodie, 1997, p. 235).

Social policies and the activities of the state are confined to the public arena and are not seen as affecting the organization of the private sphere nor as gendered (Aronson and Neysmith, 2003, p. 108). The fallacy of this separation of spheres is demonstrated by how elder care policy has a profound effect on private lives (Aronson and Neysmith, 2003, p. 108). The necessity of providing care to an elderly family member affects the daily rhythm of a carer's life, her career pattern, and future pension entitlements. Yet our current neo-liberal state defines such issues as private matters to be negotiated among family members who 'freely' enter the caring contract as 'equals' (Aronson and Neysmith, 2003, p. 108).

In addition to the concept of social reproduction and the public and private spheres, care has also been theorized in terms of ethics. Scholars of this school assert that social policy makers employ varying perspectives when undertaking ethical decisions affecting the nature of the relationship between the public and private spheres of society, and who in particular will care for Canada's growing elderly population. The 'ethic of justice' is characterized by "fairness and equality, rational decision-making based on universal rules and principles, and autonomous, impartial, and objective decision-making" (Botes, 2000, p. 1074). At the other end of the spectrum, the 'ethics of care' is constituted by caring, involvement, and the maintenance of harmonious relationships from a need-focused, holistic, and contextual viewpoint (Botes, 2000, p. 1074).

The ethic of justice is based on a rights model where problem-solving consists of the application of abstract, generalized principles to arbitrate rights disputes between separate individuals and the privilege of one right over another. “The justice-oriented problem-solver seeks a distanced stance from which to make objective decisions by applying formal rules of equality and other general principles of justice” (Bender, 37). The primary aim of the ‘ethic of justice’ is to ensure fair and equitable treatment of all people (Brook, 1987, p. 370). It is the goal of the agents who subscribe to the ‘ethic of justice’ to “let justice prevail by making verifiable and reliable decisions based on universal rules and principles” (Braybeck, 1993, p. 35). In efforts to enable objective decision-making about ethics, “the individual acts in the capacity of an autonomous, objective and impartial agent” (Edwards, 1996, p. 80).

Some liberal scholarship fails to recognize that the justice framework is not the only moral orientation in decision making (Kershaw, 2005, p. 66). A singular focus on separation in the ‘ethics of justice’ risks ignoring the reality that “connection with others is often experienced as a source of comfort and pleasure, and a protection against isolation” (Gilligan, 1987, p. 32). A second orientation, which can be referred to as the ‘ethic of care’ is also persuasive (Kershaw, 2005, p. 66). “Contrary to the individual who subscribes to the ‘ethics of justice,’ the endeavor of the person who subscribes to the ‘ethic of care’ is to fulfill the needs of the people in the ethical situation, and, in this way, to maintain harmonious relations” (Gilligan *et al.*, 1994, p. xxi).

The care orientation is grounded on the assumption that “relatedness is more fundamental than separation” (Kershaw, 2005, p. 66). According to this view, we are all unavoidably dependent upon others, living in a complicated web of dependency and caring since “human life is deeply implicated in relations of dependency and caring” (Engster, 2005, p. 61). We rely on the caring provided by others to carry out the reproduction of society, making civil life possible (Engster, 2005, p. 60). The care orientation encourages individuals to recognize that these connections with others imply mutual responsibilities, and an imperative to respond actively to the needs of others, while also cautioning against ‘cookie cutter’ application of vague principles in favor of remaining sensitive to environmental variation when deliberating in a moral fashion (Kershaw, 2005, p. 66).

Olena Hankivsky argues that “to understand the difference that the institutionalization of a care ethic could have, one must first examine the inadequacies in the normative assumptions underpinning current care policy” (2004, p. 110). According to the liberal paradigm, citizens are independent and self-reliant, along with an assumption of an equality of social relations that fails to recognize the dependencies in which we are all implicated (Hankivsky, 2004, p. 110). The caring required to sustain our lives is segregated to the private sphere thereby fostering the view that care work should not be viewed as an important part of citizenship, but rather as the natural responsibility of ‘second-class citizens,’ otherwise known as women (Hankivsky, 2004, p. 110). This segregation, naturalization and denigration demonstrates why caring has not been prioritized as part of *normal* social participation despite its permeation in our lives, creating the misunderstanding that aging is a deviation from our normal functioning, rather than an inherent part of any human experience (Hankivsky, 2004, p. 110).

In order to prioritize the importance of care, existing values and priorities fostered by our current neo-liberal paradigm require interrogation (Hankivsky, 2004, p. 111). We must abandon the model in which man is an autonomous actor, care is invisibilized, and

age and health are not factors that matter for politics (Hankivsky, 2004, p. 111). An ‘ethic of care’ can/would provide an alternative moral language for social policy making because it “elevates care to a central value in human life” (Hankivsky, 2004, p. 111). This makes the ethic of care valuable in that it provides a theoretical basis from which to challenge the status quo, and, in particular, the current trend towards deinstitutionalization, which off-loads caregiving responsibilities onto the private sphere, or, more particularly and commonly, women’s unpaid work in the private sphere of the home and family (Hankivsky, 2004, p. 106).

The Canadian Context

Theories of social reproduction, the public/private divide, and the distinction between an ethic of care and one of justice will be used to analyze the next section of this paper. This section explores the fact that Canada is about to have a disproportionate number of elderly Canadians, the effects of this profile on the care needs of the elderly, and how this increased demand for care will affect informal caregivers. Elder care social policies in Canada have been driven by a number of intersecting sociocultural, ideological, political, economic, and demographic forces (Olsen, 2003, p. 18). The proportion of elderly persons (those aged 65 and over) in Canada has been increasing over the last hundred years (Chappell, 1994, p. 233). According to the 2006 Census, the elderly population made up a record 13.7% of the total population of Canada in 2006, and “the number of people aged 65 and over increased by more than 446,700 compared with 2001 (+11.5%), topping the 4 million mark for the first time” (4.3 million) (Statistics Canada 1, 2007; Statistics Canada, 2007). By 2015, for the first time in history, Canada will have more elderly people than young people (under age 15) (Institute of Aging, 2007, p. 3). The number of people aged 55 to 64, many of whom are workers approaching retirement, has never been so high in Canada, at close to 3.7 million in 2006 (Statistics Canada, 2007). According to the most recent population projections, the proportion of seniors in the Canadian population could nearly double in the next 25 years, while the proportion of children is expected to continue to decline (Statistics Canada 3, 2007).

Baby-boomers, people born between 1946 and 1965, were between 41 and 60 years of age in 2006 (Statistics Canada 9, 2007). They represent the largest group in the population since nearly one out of three Canadians was a baby-boomer in 2006 (Statistics Canada 9, 2007). The size of this population is important because the baby-boomers limited their fertility significantly more than did their parents. This means that they will have fewer children to rely on in their old age (Statistics Canada 9, 2007). In addition, their children are more dispersed and have been ‘neo-liberalized,’ hence, less able to care due to work commitments and other demands, or simply because they have less inclination to care for the elderly in their lives.

The ‘graying’ of Canadian society will thus have a profound impact on individuals and communities, as well as social and health services, making aging one of the most significant social forces shaping our society over the next 20 to 30 years, generating a growing demand for care services (Institute of Aging, 2007, p. 3; Olsen, 2003, p. 18). Most elderly require some care in order to stay in the community, whether by themselves or with other family members. This highlights how the number of elderly Canadians requiring long-term care over the next forty years will mount considerably (Olsen, 2003, p. 2). The overall number of elders relying on others for their basic needs will continue to

expand, especially as the baby boomers approach more advanced ages (Olsen, 2003, p. 18). The effect is that there are/will be more people needing care at the same time as the state is reducing services provided in the formal system and increasing pressures on families in general, and women in particular, to fill the gaps (Armstrong and Kits, 2001, p. 28). This trend to privatize “puts renewed emphasis on the so-called ‘feminine’ sphere of the home and the ‘feminine’ qualities of selflessness, nurturing and caregiving...highlighting the saliency of gender in the era of the neo-liberal state” (Brodie, 1997, p. 237).

The aging population, the increase in longevity, and the trends towards increased individualism all add tension to the balance between the family and the state (Katz et al., 2003, 306). The growth in this segment of the population is a key policy concern because seniors are living longer (Brink, 2004, p. 1). They will likely rely primarily on family for informal care, and their larger numbers will increase the competition for limited formal care (Brink, 2004, p. 1). Informal care remains the primary source of assistance to seniors (Brink, 10). Over 90% of eldercare in Canada is provided informally, and the continued pressures of a growing elderly population and dwindling dollars will generate increasing demands (Keating et al., 1999, p. 9). In Canada, families “do the lion’s share of caring for relatives who are in need of daily assistance” (Neysmith, 2006, p. 398).

Recent reliance and emphasis on informal care raises questions about the capacity of the informal sector to maintain or increase its caring activity (Keating et al., 1999, p. 9). Addressing the need for eldercare has become more complicated as several factors combine to limit the future ability of families to provide care for Canada’s elderly in the private sphere (Connidis, 2001, p. 252). First of all, the net effect of fewer children, and the population living longer results in an increase in the proportion of elderly Canadians who do not have working-age children, which is typically the primary source of support (Connidis, 2001, p. 252). Secondly, although labor force participation has not resulted in women abandoning their parents, it has altered the fashion in which care is provided, and has amplified the need for support from the state (Connidis, 2001, p. 252). And finally, divorce in Canada is common, and divorce not only removes the support of a spouse, but also lowers the amount of support exchanged between generations (Connidis, 2001, p. 252). Divorce thus has the effect of further lessening the engagement of adult children in caregiving to elderly parents (Connidis, 2001, p. 252). Also, later marriage and childbearing, declining fertility rates, high remarriage rates, and the increasing frequency of displacement also mean that many miles separate potential informal caregivers from family and friends in need, adding to the factors that result in fewer adult children who are/will be able to care for elderly parents in ill health (Frederick and Fast, 26).

Feminists have illuminated the power inequalities implicit in expectations of feminine selflessness and self-sacrifice that shape the gender distribution of care (Kershaw, 2005, p. 75). Research reveals that responsibility for caring typically falls to women (wives, daughters, daughters-in-law) rather than men (Aronson and Neysmith, 2003, p. 98). The rapid growth of the elderly population has led to a greater need for supportive services, while at the same time government policies have reinforced women’s obligations for the elderly (Olsen, 2003, p. 7). Analysis of this pattern highlights its origins in gender socialization, and explains differences in how caring is experienced subjectively, “as an obligation for women and as an active choice for men” (Aronson and Neysmith, 2003, p. 99). In Canada, women are commonly pressed into caring by virtue of the absence of alternatives for the elderly in their lives (Aronson and Neysmith, 2003, p. 99). Regardless

of their employment status and occupation, women are typically responsible for work in the home, including caregiving for the elderly (Kershaw, 2005, p. 90). An interesting aspect of the care work that women provide is that the proportion done is difficult to calculate because it is not counted as work of social value (Aronson and Neysmith, 2003, p. 97).

The costs to women of providing care are varied and often costly (Aronson and Neysmith, 2003, p. 100). For reasonably healthy elderly people, care might mean practical help with shopping or heavy housework, emotional support, and the continuation of an otherwise reciprocal relationship (Aronson and Neysmith, 2003, p. 100). For elderly people with more serious physical and mental impairments, it can involve twenty-four hour care (Aronson and Neysmith, 2003, p. 100). For example, it can prompt younger women to withdraw from the labor force or decide not to seek advancement in their paid work. Ultimately these decisions often lead to diminished income leading to lower pension entitlements in their old age (Aronson and Neysmith, 2003, p. 100).

Caregivers are juggling competing demands, from full-time employment to other social activities, and a lack of time for themselves (Certified General Accountants, 2005, p. 58). Other impacts and conflicts reported include extra expenses, employment consequences such as reduced hours of work, lost income, loss of job and delaying education or employment (Certified General Accountants, 2005, p. 58). Caregivers who report strain associated with care-giving are themselves at increased risk of developing their own health problems, including depression, anxiety, and lower levels of health (Certified General Accountants, 2005, p. 58). Such strains can result in physical/mental exhaustion or illness for the carer (Aronson and Neysmith, 2003, p. 100). “The implications for family carers of public cost-cutting, and the deceptive rhetoric of community-based care take the shape of unpaid work that, even if lovingly and willingly given, is jeopardized by the lack of publicly provided alternatives, and can be costly” (Aronson and Neysmith, 2003, p. 101).

Residualism entails an ideological stress on self-reliance and individualism, as well as government retrenchment, decentralization, familism, and privatization. Janine Brodie defines the concept as “the unverifiable claim that services and assets initially created in the public sector are better delivered and maintained through market mechanisms and the price system” (1997, p. 236). An important consequence of a residualist orientation to governance is that the distribution of social welfare becomes increasingly “bifurcated between those who can afford to buy superior service from the private sector and those who remain tied to the eroding public system” (Brodie, 1997, p. 236). Women are disproportionately burdened by these developments (Olsen, 2003, p. 8). Caregiving is not only an expectation but is also considered a *normal* experience for women, many of whom are single and discharging their responsibility without any financial or other help (Olsen, 2003, p. 241). Moreover, policymakers have enacted policies and cost-containment measures that shift ever greater burdens on women who are increasingly incapable of meeting the demands placed on them (Olsen, 2003, p. 241).

The national policy context with respect to the elderly is rapidly changing in Canada because of tightening fiscal constraints in the provision of publicly funded programs and services that have been the thrust for changes in health policies and in the broad formal system of care (Martin-Matthews, 1999, p. 11). This fiscal and economic restructuring of health and social services has been accompanied by a change in philosophy about how best to meet seniors’ needs (Frederick and Fast, 26). Thus, in effect, emphasis

has changed from the institutional care of patients to community-based care, which relies heavily on caregiving assistance from family and friends (Frederick and Fast, 26).

As governments have been increasingly driven by deficit reduction and cost-cutting objectives, community care has been embraced (Aronson and Neysmith, 2003, p. 89). Community care is presented as an uncontroversial, sensible way of responding to Canada's elderly citizens' needs while also averting demographic and fiscal crisis (Aronson and Neysmith, 2003, p. 89). Reduced hospitalization and postponement of institutionalization can decrease costs, enhance quality of life, and provide greater choice for seniors (Certified General Accountants, 2005, p. 65). However, the successful rhetoric of the shift to community/home care in Canadian policy has not been accompanied by a corresponding shift in policy resources (Aronson and Neysmith, 2003, p. 89). The shift actually signifies the privatizing of the costs and work associated with family in old age, and a reframing of the relationship between elderly citizens and the state; in effect, the Canadian state is revising previously made promises of social security (Aronson and Neysmith, 2003, p. 89). And, while each province has some form of community-based care legislation, Canada does not have a national home and community care program like, for example, what exists in Australia, a country with many similar state structures (Neysmith, 2006, p. 402).

Recent policies pertaining to deinstitutionalization are premised on a plethora of faulty assumptions requiring detangling (Hankivsky, 2004, p. 107). "This logic of cost-containment that has become numbingly ordinary in public debate shrouds the reality that the costs of elder care are being redistributed to the private sphere" (Aronson and Neysmith, 2003, p. 93). In elder care, the costs of frailty and care are simply hidden from public view in the private lives and homes of the elderly and their families (Aronson and Neysmith, 2003, p. 93). Policy makers assume that there is an unlimited pool of private labor to provide home care that is "subject to the pressures of affect, kinship obligation, duty, reciprocity, biography, altruism and habit" (Hankivsky, 2004, p. 107). Built into these assumptions is that there is a home, and some form of family to care for Canada's elderly who are dependent (Hankivsky, 2004, p. 108). A tangible example of this is the trend of Canadian hospitals reducing the length of stays by sending patients home more quickly than ever, thereby shifting costs to family members and friends (Folbre, 2001, p. 59). In response to financial constraints and a lack of health care professionals, health care is now organized to ensure that people with acute problems are discharged as quickly as possible from expensive hospital care (Aronson and Neysmith, 2003, p. 91). Moreover, demonstrating that caring for Canada's elderly is seen by Canadian policy makers as a private responsibility (Hankivsky, 2004, p. 107). This 'dehospitalizing' and cost-cutting means that increasing numbers of elderly people live in their own homes, often requiring support to do so in a safe manner (Aronson and Neysmith, 2003, p. 91).

As the language of private economic enterprise has enveloped a discussion of social programs, such allusions to preference and choice have become commonplace (Aronson and Neysmith, 2003, p. 94). We hear less now of the elderly population's entitlements of citizenship than we do about elderly consumers' rights to exercise 'choice' in the elder care 'marketplace' (Aronson and Neysmith, 2003, p. 94). Feminist critiques have highlighted how the liberal state focuses narrowly on the individual and 'his' freedom of action (Aronson and Neysmith, 2003, p. 108). This status influences their power or positioning and determines their freedom of action and ability to negotiate (Aronson and Neysmith,

2003, p. 108). Translated into the arena of elder care, this construction of individuals as free and equal actors means, for example, that family carers are seen to do their caring work by choice and that elderly people are seen as ‘choosing’ to rely on them (Aronson and Neysmith, 2003, p. 108).

Closely examined, these images of choice and involvement prove hollow and misleading (Aronson and Neysmith, 2003, p. 94). Preferences and alternatives can be exercised only if real alternatives exist or can be demanded, and if knowledge about them is accessible (Aronson and Neysmith, 2003, p. 94). In a minority of situations, choice may indeed be exercised (Aronson and Neysmith, 2003, p. 108). “The possibility of choice is greatest where financial resources are sufficient to purchase services and when a spouse is present and in reasonably good health; and the care needs of the elderly person are minimal” (Aronson and Neysmith, 2003, p. 108). These conditions are exceptional; many of Canada’s elderly are widows with limited resources, they do not have readily available kin on whom they want to depend, and most elderly people needing care require it with relative frequency (Aronson and Neysmith, 2003, p. 108). “These conditions are not satisfied when, in reality, elderly people face a shrinking institutional sector, already unattractive by virtue of its forbidding history; fragmented and often meagerly funded home care services; and, as a result, enforced dependence on the care of relatives, if they have any” (Aronson and Neysmith, 2003, p. 94).

Pressure to cut costs creates new openings for private, profit-oriented providers that focus on the financial ‘bottom-line’ (Folbre, 2001, p. 56). Unfortunately, “in the tug of war between costs and care, it is care that seems to be losing” (Folbre, 2001, p. 58). Canadian elders often have little or no choice about where or how they will be cared for (Folbre, 2001, p. 60). Accordingly, anxiety about quality runs high in market-provided elder care, as complaints about abusive treatment are often ignored, wages for workers in elder care are low, and turnover rates increase (Folbre, 2001, p. 60-61). Unfortunately this is one way that our current state system allows Canada’s elderly to fall through the cracks. Granted, for those with sufficient resources, there is the option to purchase care from commercial firms, if these exist where one lives (Neysmith, 2006, p. 400). Yet many of those who most need care services for themselves or their dependents do not have the resources to buy them (Folbre, 2001, p. 49). In addition, “like all market transactions, . . . it is a case of ‘buyer beware’” (Neysmith, 2006, p. 400).

Policy Responses – the Veterans’ Independence Program (VIP)

Social policy has the potential to play an important role in enhancing the independence of elderly Canadians (Connidis, 2001, 251). Pensions for the elderly, for example, ostensibly allow individuals to care for and purchase care for themselves so that they are not dependent on their families (Jenson, 2002, p. 70). It is important to consider that the expenditures in one policy field can have consequences for the costs and outcomes of other related policy fields (Brink, 2004, p. 1). Social policy should examine the issues of elder care through the nexus of family, work and health policy, rather than dealing with these policies individually” (Brink, 2004, p. 1). This type of change in Canada’s social policy is necessary because “old practices are not solutions to new problems” when it comes to elder care social policy design (Jenson, 2004, p. 39).

Social policy should now be engineered with Canada’s aging society in mind so that the state can adjust and design infrastructure, policies, plans, and resources which

celebrate increased longevity and reduce dependencies on family, minimizing intergenerational conflict, categorization and stigmatization (Certified General Accountants, 2005, p. 12). Policy makers should be encouraged to consider the full range of dynamics and interactions between people of different age groups and to frame policy using the life course as the unit of analysis because “aging is not defined by chronological age alone, is non-discriminate, and is neither linear nor static” (Certified General Accountants, 2005, p. 12).

Elderly people’s own accounts of what it is like to need care from family reflects the insecurity of their dependent positioning (Aronson and Neysmith, 2003, p. 95). Relying on family members’ help for care often evokes feelings of indebtedness and clashes with closely held ideas about independence and self-reliance (Aronson and Neysmith, 2003, p. 95). Research shows that 90% of Canadians would prefer to spend their final years at home, favoring help from formal services over family care (Certified General Accountants, 2005, p. 58; Daatland, 1990; Aronson and Neysmith, 2003, p. 95).

An aging population presents different policy challenges than a demographically young nation; however, whether this develops into a ‘caring problem’ depends on how the issue is taken up. In other words, how the demographic fact is addressed by social policy determines whether or not an aging population constitutes a ‘crisis’ (Neysmith, 2006, p. 397). Recognition that other liberal welfare states faced with similar fiscal pressures have pursued alternative policies in elder care “exposes the actions of the Canadian state as accumulated political choices rather than neutral inevitabilities” (Aronson and Neysmith, 2003, p. 107).

Most elderly Canadians value their independence, have lived in their communities most of their lives, and have friends and family who visit them from close by (Hinton, 2007). Some continue to live independently with the support of programs like *Meals on Wheels* and home help that assist with housework, personal hygiene, and medical procedures (Cancian and Oliker, 2000, p. 68). Unfortunately, when these services are not provided as part of a program administered by the state they tend to be too expensive and often unavailable for the majority of elderly people to access. This highlights the need for a national home care program to provide care for Canada’s aging population. While theories of social reproduction, the public and the private sphere, and the ethics of justice and care are important analytical tools when examining elder care social policy, the ethics of care are only modestly applicable to most programs for the elderly in Canada.

The *Veterans Independence Program* (VIP) is a notable exception. VIP is the national home care program that offers the “delivery of benefits and services that contribute to the independence, quality of life, and standard of living of Canada's war Veterans, eligible Canadian Forces Veterans and still-serving members, RCMP clients, qualified civilians, and their families in recognition of their sacrifice to the nation” (V.A.C. 4). VIP developed to provide services that would eliminate or delay the need for institutionalizing older veterans (Government of Canada, 1987, p. 1). The goal of VIP is to help veterans remain healthy and independent in their own homes and communities for as long as possible (Hinton, 2007).

The VIP was introduced in 1981, initially under the name *Aging Veterans Program*. It is one of the most innovative and popular programs offered by Veterans Affairs Canada (Hinton, 2007; V.A.C. 6). Initially, the VIP was only available to war disability pensioners for long-term health needs related to the condition(s) for which they

were pensioned (Government of Canada, 1987, p. 1). In 1984, the Government of Canada approved an extension of eligibility for the VIP to include a greater number of veterans (Government of Canada, 1987, p. 1).

The program has grown in both importance and numbers of ‘clients’ (Hinton, 2007). It is now available to more ‘clients’ than ever before, and “today, there are about 94,500 Canadians across the country who receive VIP” (Hinton, 2007). About 70,500 of these recipients are veterans, which includes war service veterans, and younger Canadian Forces veterans, in addition to 24,000 primary caregivers who also benefit from the program (Hinton, 2007). After the recipient of VIP has passed away their informal caregivers are also provided with housekeeping and/or grounds keeping services, depending on what the veteran was receiving at the time of death (Hinton, 2007). These programs are available for as long as they are needed since many veterans have been cared for by individuals who are now elderly (V.A.C. 6). “Most of the primary caregivers considered in this proposed amendment are in their 70s and 80s” (V.A.C. 6). These caregivers have health concerns of their own and the provision of *Veterans Independence Program* services is a way to alleviate them (V.A.C. 6).

The VIP home care program offers veterans and other eligible persons self-managed care in co-operation with provincial and regional health authorities to foster their independence in their own homes and communities (V.A.C. 6). *Veterans Affairs Canada* (V.A.C.) recognizes that the VIP client base continues to change, partially because of the advancing age and deteriorating health of Veterans (V.A.C. 4). In recognition of this, “VIP services are very much in demand, and V.A.C. continues to be innovative in adapting its programs and services to meet all of the clients’ needs, demonstrating how VIP provides ‘client-centered’ benefits and services that respond to the needs of [their] family of clients” (V.A.C. 4).

The original program offered financial support for Home Care, Home Adaptation, Ambulatory Health Care, Adult Residential Care, and Nursing Home Intermediate Care (Government of Canada, 1987, p.2). Table 1 below lists the services offered by the program. The extended program now also includes transportation with restricted eligibility (Government of Canada, 1987, p.2).

Table 1 Veterans Independence Program paid services offered by the Canadian state to veterans.

VIP Paid Services	Description	Service Activities
Grounds Maintenance (V.A.C.2, 31)	Activities regularly required to maintain the yard/area surrounding the client’s principal residence.	Includes: <ul style="list-style-type: none"> • snow removal from steps, walkways, and driveways • snow and ice removal from roofs and eaves troughs • lawn mowing and raking
Housekeeping (V.A.C.2, 32)	1. Routine tasks or domestic chores required to support the client in remaining self-sufficient at their principal	Includes: <ul style="list-style-type: none"> • laundry, • vacuuming, • cleaning floors,

VIP Paid Services	Description	Service Activities
	<p>residence.</p> <p>2. "Certain non-routine tasks or domestic chores may also be covered, with pre-authorization by V.A.C., and only if they are required as a result of the client's health and safety being at risk".</p>	<ul style="list-style-type: none"> • dusting, • general picking up, • meal preparation
<p>Personal Care (V.A.C.2, 32)</p>	<p>Approved services provided by individuals such as V.A.C. approved Health Care Providers or Professionals. "These services include assistance in the performance of daily living and supervision required by clients who cannot be left unattended."</p>	<p>Assistance with:</p> <ul style="list-style-type: none"> • eating, • dressing, • washing, • grooming, • adjusting prosthetic appliances, • attending to toileting, • ambulation, • respite care
<p>Home Adaptations (V.A.C.2, 33)</p>	<p>Can be made to a client's principal residence to facilitate access for basic everyday activities such as food preparation, personal hygiene, and sleep.</p>	<p>Includes modifications to:</p> <ul style="list-style-type: none"> • bathrooms, • kitchens, • doorways • installing handrails on stairways, • house additions
<p>Access To Nutrition Services (V.A.C.2, 33-34)</p>	<p>Facilitating access to nutritional food, whether it is delivered to the client's home, offered in the community, or served at a local restaurant.</p>	<p>Includes:</p> <ul style="list-style-type: none"> • cost of delivering food to the home, • transportation cost to bring the client to a local restaurant or community facility to obtain meals
<p>Health And Support Services (V.A.C.2, 34)</p>	<p>Provided by health professionals. However, these can be provided only when they are not insured services under a private health care system or available to clients as residents of a province.</p>	<p>Includes:</p> <ul style="list-style-type: none"> • health assessments • diagnostic services, • care, • maintenance, • related personal care provided by health professionals
<p>Ambulatory Health Care (V.A.C.2, 34)</p>	<p>Ambulatory health care covers certain health and social services provided outside the home, by and under the supervision of a health professional.</p>	<p>Includes:</p> <ul style="list-style-type: none"> • adult daycare, • travel costs to access these services

VIP Paid Services	Description	Service Activities
Intermediate Care Services (V.A.C.2, 35)	Obtainable, and may be provided when living at home is no longer practical and a greater level of nursing and personal assistance is needed in a Long Term Care Facility. In addition, eligible clients may also qualify for assistance with chronic care.	
Transportation Services (V.A.C.2, 35)	To facilitate clients' participation in social activities, in response to the client's basic social, recreational, or personal needs.	When transportation is not otherwise available these may include: <ul style="list-style-type: none"> • transportation to church services, • occasional visits to friends/relatives, • community centers, • banks, • grocery stores,

The *Veterans Independence Program* is designed to assist with the costs of the services shown in Table 1 provided at the client's home (V.A.C.2, 31). VIP offers a customized plan for each client based on a needs assessment (Hinton), thus, ability to access VIP services depends on health needs, and if these services are available through another federal, provincial or municipal program (V.A.C., 5). Services under the VIP are provided on the basis of an assessment indicating that they are required for health reasons, and to help the recipient live a self-sufficient life in their own home (V.A.C. 6). V.A.C. determines the eligibility of individuals who apply for VIP benefits and "applicants' needs are identified by a multi-disciplinary team using a client-centered service approach" (V.A.C. 6). It is then determined whether needs can be filled using departmental programs, the provincial health system, regional community resources, or a combination thereof (V.A.C. 6). "Emphasis and priority are placed on clients with the greatest level of risk to health or of institutionalization" (V.A.C. 6).

The VIP comprises payments and services (Government of Canada, 1987, p.2). Payments may be made by the Department when needed benefits are not fully covered by community programs, and if those benefits promote independent, healthy living (Government of Canada, 1987, p.2). If a local agency offers a benefit for which the veteran is eligible, that benefit is to be accessed first (Government of Canada, 1987, p.2). If what is offered through the local agency is not sufficient to meet the client's needs, the Department will contribute funds up to an established limit. "While the primary responsibility for the delivery of health care to all citizens rests with the provinces, the Veterans Independence Program provides payment or services required either to complement those offered locally or to make available needed services which local agencies do not provide" (Government of Canada, 1987, p. 5). The VIP does not replace existing health care programs, rather, it provides payment for additional services required to enable veterans to remain independent

and healthy, preferably in their own homes (Government of Canada, 1987, p. 5). Services provided by the VIP may be delivered by the 'client's' service provider of choice (V.A.C. 6). "Claims are processed by a third-party contractor in accordance with the regulations and other parameters established by Veterans Affairs Canada" (V.A.C. 6).

Although one might be tempted to argue that this program is gender-biased in favor of men, this is not strictly true since their wives also benefit, as do women veterans. In fact, my inspiration for this paper was my Great Aunt Margaret, who is shown in her Royal Canadian Air Force (Women's Division) uniform in the picture featured on the title page of this paper. Along with many other Canadian women, she served from 1942 until 1946 as a first-class Corporal. As a Veteran, she makes use of the *Veterans Independence Program* which has allowed her to remain residing in her original home, living a happy, healthy, independent life at age eighty-seven. When interviewed for the purposes of this paper she made it clear that without these services she would be unable to maintain her preferred independent lifestyle.

By promoting independence and an improved quality of life, VIP clients are facilitated in continuing to be valuable, contributing members of their communities and society (V.A.C. 4). For these reasons, the VIP program has become a model for home care, both in Canada and throughout the world (Hinton, 2007). Veterans Affairs Canada's stated strategic direction over the next three years is to "continue to provide exemplary client-centered service and to support the health and wellness of [their] clientele as [they] strive to meet the needs of [their] aging War Service Veterans and the younger modern day Canadian Forces Veterans and members" (V.A.C. 3).

It is useful to question how/why it is possible for the VIP to 'swim against the tide' towards devolving care responsibilities onto families. Veterans Affairs Canada's stated direction demonstrates that the Canadian state remains committed to ensuring that its programs and services meet the changing needs of its veteran clientele. VIP services honor the sacrifices and achievements of Canada's veterans (Veterans Affairs Canada, 2006, p. 1). VIP represents an opportunity to further repay a 'debt of gratitude' to these 'special Canadians' (V.A.C. 6). We must interrogate why the rest of Canada's elderly population, who have contributed to Canadian society in different, yet also important ways, are not extended these same, or similar services.

There are unstated assumptions underpinning institutions in place for Canada's Veterans. The ethic of justice employed as a rationale for offering VIP to Veterans, excludes the rest of Canada's elderly. Inherent in this thinking are assumptions about veterans' entitlements, with the sacrifices and achievements of Canada's veterans used as the justification for their claim to these types of services/programs. VIP is a form of 'payback' for veterans' services in the past, demonstrating an ethic of justice at work because those eligible for VIP are receiving these services based on entitlement, rather than on the basis of need, and used as justification for the limitation of VIP services to those considered 'worthy.' This 'balancing of scales' approach to providing services is not adequate to meet the needs of Canada's elderly.

The rationale deployed to justify this differential treatment of veterans is inherently flawed. Military service should not be considered a more significant contribution to the state than work performed by the rest of Canada. It is unjust to provide elder care services to a portion of the population, while not providing it for the rest of Canada's elderly. In efforts to rectify the care imbalances, and uncertainties experienced by many of Canada's

elderly, a positive and progressive amendment would be to extend the VIP home care benefits to all elderly Canadians. Extension of VIP services would enable all elderly Canadians to remain healthy and independent in their own homes and communities for as long as possible (Hinton, 2007), and would assist with their health and wellness, thereby promoting independence and improving their quality of life until long term care becomes an absolute necessity (V.A.C. 4).

How might this program be made politically palatable to governments and voters? In order for this to happen, care must become publicly valued. This will require a fundamental change in our approach to caring because in order to achieve this increased socialization of care Canadians must acknowledge the importance of care as a social and political concern (Tronto, 1995, p. 135-6). In this way, the state will become responsible for the provision of basic necessary home care for Canada's elderly, and become responsible for insuring a reasonable minimum level of elder care standards (Tronto, 1995, p. 135).

In order to develop public policies that assure elderly citizens access to specialized elder care services and that distribute their costs equitably, the active intervention of federal and provincial governments is needed (Aronson and Neysmith, 2003, p. 107). We know, for example, that in countries like Sweden and Denmark, where an active state exists, women have registered real gains from policies that recognize the social benefits accruing from elder care programs (Aronson and Neysmith, 2003, p. 107). We can identify examples of similar gains in Canada; for instance, despite resistance from the market sector, federal and provincial governments initiated pay and employment equity policies, as well as property-splitting at divorce, anti-violence programs and welfare schemes that have benefited different groups of women (Aronson and Neysmith, 2003, p. 107). These observations are presented to provide social context to the current debate so that we can recognize the possibilities of more active state intervention (Aronson and Neysmith, 2003, p. 108).

Elder care policy should be framed to ensure that it meets the needs of Canada's growing elderly population (Aronson and Neysmith, 2003, p. 109). This framing of elder care policy would transform elderly 'consumers' into elderly 'citizens' with rights (Aronson and Neysmith, 2003, p. 109). "It would also make visible the political nature of need interpretation and responses to defined need" (Aronson and Neysmith, 2003, p. 109). Acknowledgement of politically determined phenomena, need definition, services, and programs would be revealed as open to contestation, instead of depicted as the inevitable and undebatable results of market forces (Aronson and Neysmith, 2003, p. 109). This transformation of elderly consumers into politically positioned citizens requires a reframing of the nature of welfare pluralism in Canada (Aronson and Neysmith, 2003, p. 109).

Canadian citizens deserve, and should expect a high quality of life in their elder years. A minimal level of care is a necessity, not a luxury (Folbre, 2001, p. 49). Policies increasing the ability of elderly Canadians to help themselves, supporting families in the comprehensive care they offer elderly Canadians serve the interests of all family members because high-quality care produces benefits that extend beyond the immediate recipients by enhancing the independence of elderly individuals, thereby reducing dependence on families (Connidis, 2001, p. 261-267; Folbre, 2001, p. 50). If implemented and publicly subsidized or funded, the VIP would bolster the ability of Canada's elderly to remain in the community, either independently, or with the support of family (Connidis, 2001, p. 261).

In order to encourage and expand the implementation of publicly funded programs of this nature, it will first be essential to rearrange our beliefs about the importance of care, existing values and priorities fostered by our current neo-liberal paradigm (Hankivsky, 2004, p. 111). We must develop and advance a fundamentally different model for social policy that understands the importance of social programs to create a culture that values and prioritizes caregiving by deploying the ethics of care, recognizing our social interdependencies and the significance of caregiving work (McKeen, 2006, p. 883; Hankivsky, 2004, p. 111). It should also be understood that these observations about depending upon relatives of a younger generation capture the realities of only one segment of the elderly population. We know less about elderly people's experiences of relying on elderly spouses for care and support (Aronson and Neysmith, 2003, p. 96). Significantly, too, relatively little research attention has been given to people who do not have children, who do not live in heterosexual partnerships or who do not live in Western, nuclear family forms – in short, “those who do not fit in with the homogenous picture of ‘family care’ painted in the elder care discourse” (Aronson and Neysmith, 2003, p. 96). Research on the diversity of social ties can both expand the narrowed framing of ‘family care’ that underpins social policy discourse and highlight groups who face frailty in old age in especially unsupported circumstances (Aronson and Neysmith, 2003, p. 96). It is timely for Canadian social policy to begin reflecting reality by creating and extending policies like the *Veterans Independence Program* that would ensure the health and well-being of our elderly population. This will translate into amelioration in the quality of life for all Canadians.

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