Running Head: PROVINCIAL SUPPORTS FOR FAMILY/FRIEND CAREGIVERS

Mount Saint Vincent University

Department of Family Studies and Gerontology

Analyzing Provincial Supports for Family/Friend Caregivers: A Comparison of the Manitoba Primary Caregiver Tax Credit and the Nova Scotia Caregiver Benefit

By

Megan Elizabeth O'Hara

Submitted in partial fulfillment of the requirements of the degree of

Masters of Arts in Family Studies and Gerontology

Date August 29, 2014

Mount Saint Vincent University

Department of Family Studies and Gerontology

A Comparison of the Manitoba Primary Caregiver Tax Credit and the Nova Scotia Caregiver Benefit

By

Megan Elizabeth O'Hara

Approved:

_____

Janice Keefe, Ph.D.
Professor of Family Studies and Gerontology

_____

Pamela Fancey, MA
Associate Director/Research Associate Nova Scotia Centre on Aging, MSVU

_____

Susan Stevens, Med, RSW
Director, System Planning, Continuing Care Branch, NS Department of Health and Wellness

Dedication

To my mom Libby and brother Ryan who have always encouraged me to try my best, and have been great sources of advice and support throughout the entirety of my post-secondary education. To Kevin Gormley, my better half, who has also been a major source of support, love and humor throughout this process. To my 'kindred spirit' Sacha Nadeau who has been my friend and 'sidekick' for the past 3 years, as well as a great source of support.

To my grandparents whose stories and lives helped develop and confirm my interest in gerontology. To my friends and extended family, who always make me laugh and feel loved, you are all very special to me.

Lastly to my dad J. Paul, whose memory and legacy gave me the drive to finish my Bachelor's degree and continue on to pursue a Master's degree (I.C.S.U).

And as my dad use to say;

May the road rise to meet you.

May the wind be always at your back.

May the sun shine warm upon your face,

And rains fall soft upon your fields.

And until we meet again,

May your favorite song play in your mind and heart.

Acknowledgments

I would like to thank and acknowledge Dr. Janice Keefe for her time, wisdom and advice over the past three years. Her knowledge and ability is admirable and I have greatly appreciated being her student and employee. I have learned so much under her tutelage, for which I am forever grateful. I would also like to acknowledge my committee members Pamela Fancey and Susan Stevens for their time and guidance throughout this process. A thank you is also due to Krista White and Rachel Ogilvie who were a tremendous help to me. Lastly I would like to thank and acknowledge my key informant interviewees who took time out of their busy schedules to participate in my research.

Abstract

As Canada's population continues to age, provincial/territorial governments will increasingly rely on the work and support of family/friend caregivers. Family/friend caregivers often experience financial, emotional physical and social stresses that can be directly related to their role as an unpaid caregiver. The accumulated work of family/friend caregivers can amount to billions of dollars each year, and yet they often receive no financial assistance in return. Manitoba and Nova Scotia are two provinces who have implemented policies meant to recognize the important roles of family/friend caregivers.

Through conducting an in-depth policy analysis, key informant interviews with policy experts/creators and caregiver advocates, and a secondary data analysis of the Manitoba Primary Caregiver Tax Credit and the Nova Scotia Caregiver Benefit, it was found that these supports are positive social and economic components of each provincial budget. More people access the Primary Caregiver Tax Credit in the Winnipeg Regional Health Authority (which contains the province's largest city) than in the other RHAs combined. In comparison, more people access the Nova Scotia Caregiver Benefit in the combined District Health Authorities of Nova Scotia, than in the DHA that includes the province's largest city of Halifax.

These supports were implemented as a means of recognizing and supporting family/friend caregivers during the duration of their caregiving roles. There is evidence, that such supports can prolong a caregiving relationship by helping the older adult remain in the home. In Nova Scotia specifically, it was found that relationships that receive the caregiver benefit are far less likely to end with the care recipient entering long-term care.

This in turn, has the potential to save the provincial government thousands of dollars each year. Future research should consider the individual experiences and perception of caregivers receiving the benefits in each province. This research provides beginning evidence from administrative data about the role policy may play in supporting caregivers. Other provinces might benefit from assessing the utility of these policies in their jurisdictions.

Table of Contents

List of Figures

List of Tables

Chapter 1: Introduction

After the Second World War, Canada experienced a huge growth in its population due to an increase in total number of births. With this demographic change came the need for the implementation of new policies that would suit the needs of this large group of children. Now that this birth cohort (who has become known as the "Baby Boomer" generation) has started to reach age 65, there is a need for responsive policy to meet their changing needs. Many baby boomers are now providing care to a family member or friend, but may soon require family/friend caregivers themselves, so that they may remain in their own homes as they age. For this reason, it is critically important for Government, both federal and provincial/territorial; to implement policies that recognize the challenges being faced by family/friend caregivers and mitigate these challenges in order to sustain the family/friend caregiver workforce.

When considering Canada's current economic climate, the sustainability of the health care system and an aging population, it is paramount to raise the question of who will be responsible to provide care to Canada's dependent older population in the future, as the baby boomers begin to require care. Canada is not the only country facing such challenges: "Many countries are facing concerns about their ability to maintain the welfare state, given global demographic changes of declining birth rates and aging population" (Keefe & Rajnovich, 2007, p. 83). Given these factors, it is difficult to ascertain who should be responsible for funding and providing care to Canada's aging population. Should it be the financial responsibility of the Federal Government, whose 1984 Canada Health Act fails to include home and long term care as insured services?

Should it be family/friend caregivers? If so, in what ways will the government support the family/friend caregiver workforce (or should the government support caregivers)? Once these questions are addressed, the rationale for supporting family/friend caregivers must then be decided, "whether or not financial support will be introduced for economic reasons (maintaining costs) or social reasons (valuing the care provided)" (Keefe & Rajnovich, 2007, p. 80). As the older population grows and more individuals require health-related care and assistance with their activities of daily living, the value systems of governments and society may have to shift to better support family/friend caregivers, so that they are not left to provide a level of care that has the potential to cause harm whether financial, physical or social.

The involvement of the federal and/or provincial/territorial governments in designing caregiver policy is limited to the policy domains under their jurisdiction. The Federal government has access to domains involving income security and pension, labour and taxation but not the provision of health services (except for very specific populations). The Provinces and Territories are responsible to ensure delivery of health services but would argue their capacity to support new policies is handicapped by the funding received as part of the Health Accord. In addition, the choice to implement policies to support family/friend caregivers may be driven by specific values held by the political parties, policy makers and societal values of the time. It has been suggested that policies should be based on both empirical evidence and an ethical framework, as they tend to encompass the collective values of those who created them (Keefe & Rajnovich, 2007). Furthermore, it is noteworthy to consider whether policies are implemented for economic or social reasons. Policies implemented for economic reasons are intended to

provide cost savings to the health care system and ultimately delay or negate the need for institutionalization. Policies implemented with social objectives seek to recognize and support the contributions of caregivers and also to support the informal care system (Keefe & Rajnovich, 2007).

Through the Canadian Health Act of 1984, the Federal Government legislated that Canadian provinces/territories must follow certain criteria when delivering their public health care insurance plans in order to qualify for the full federal cash contribution under the Canada Health Transfer. The criteria include public administration, comprehensiveness, universality, portability and accessibility (Parliament of Canada, 2013). Provinces/territories must consider these criteria while delivering health care (primarily acute and physician care), when, "determining how many hospital beds will be available in a province; deciding what categories of staff will be hired; determining how the system will serve the population; approving hospital budgets; and negotiating fee scales with the medical association and other health professional organizations" (Parliament of Canada, 2013). When considering that the Canada Health Act mandates Canadian provinces/territories to provide health care equally to all citizens, it is essential to consider the impact that Canada's aging population may have on this system. As individuals age, they may acquire health-related issues that require medical care. Common aging-related changes such as reduced functional ability, necessary to perform activities of daily living, may not require medical care but instead may require some form of support or assistance. Consequently, all of the needs of older adults may not fall under the mandate of the CHA. The type of care and support required by an aging population

has the potential to be costly and raises the question of who is responsible to provide this seemingly unavoidable population-level increase in care and support?

There are a number of supportive policies that Canadian governments have chosen to implement as a means of supporting their family/friend caregivers. Some Canadian provinces/territories have begun to use their taxation systems to acknowledge family/friend caregivers. The province of Manitoba for example, is one of only three Canadian provinces to implement a refundable tax credit available to family/friend caregivers. Nova Scotia offers family/friend caregivers financial assistance through their Caregiver Benefit. Although these two financial supports have a similar goal, that of recognizing and supporting family/friend caregivers, the means they use to achieve this goal differs greatly. This research used a case study approach to analyze the Manitoba Primary Caregiver Tax Credit and the Nova Scotia Caregiver Benefit. Utilizing this type of analysis helped to facilitate an understanding of the circumstances that led to the policies' implementation, the benefits and limitations of each policy, the uptake of the support and where there is room for improvement.

Given that a large portion of the Canadian population, the leading edge baby boomers, have already begun to reach age 65; within the next decade a greater number of people will require support and medical care. If Government attention is not put towards supporting informal care (family/friend caregivers), provincial/territorial governments will incur the increased cost associated with caring for our aging population through formal mechanisms (e.g., publically-funded home care, long term care beds). Often, family/friend caregivers provide care and support to older adults without receiving any financial compensation for their time or their out-of-pocket expenses. This lack of

compensation and recognition often results in the caregiver having to alter their work, family and social lives. It is critical that new policies recognize and support family/friend caregivers in order to sustain the caregiving relationship – for both economic and social reasons.

Chapter 2: Conceptual Framework

The conceptual framework used as the foundation to this research was the Andersen Newman Model. The Andersen Newman model provides a framework to understand access to services and supports within the health care system. It also facilitates an understanding of family/friend caregivers, who are most likely to access the Primary Caregiver Tax Credit of Manitoba and Nova Scotia's Caregiver Benefit. In its original form, the Andersen Newman model sought to determine "why families use health services; to define and measure equitable access to health care and to assist in developing policies and to promote equitable access" (Andersen, 1995, p. 5). In considering the original intent of the model, it may also be used to explain why some family/friend caregivers access supportive services, by examining three factors; predisposing factors, enabling factors, and need factors. These three factors were used to examine the usage of the Manitoba Primary Caregiver Tax Credit and the Nova Scotia Caregiver Benefit by family/friend caregivers.

Because of the steady increase in the older Canadian population, there may soon be more family/friend caregivers, who will attempt to access various supports available through provincial/territorial governments. It will be a desired outcome that these caregiver supports will act as a means to sustain the caregiving relationship and offset some of the costs associated with these relationships. For this reason, it is important to highlight what type of family/friend caregivers are most likely to access and/or need financial assistance. Recognizing the shared characteristics among Canadian family/friend caregivers who are most likely to access fully-refundable tax credits and benefits could aid in the implementation of policies that would benefit more Canadian

family/friend caregivers. The Andersen Newman Model assisted in uncovering these shared characteristics.

The first of the identified factors, predisposing factor, recognizes that some individuals have characteristics that are not a result of illness, but rather were inherent to the individual prior. Here, illness will be substituted for some form of supportive service. The characteristics that fall under predisposing factors can include demographic, social structural and attitudinal-belief variables (Andersen & Newman, 1973). Elements that can be found within demographic, social structural and attitudinal-belief, can include elements such as age and sex (Hawkins, 2005). The aforementioned characteristics have the potential to influence whether or not a person attempts to access the Manitoba Primary Caregiver Tax Credit or the Nova Scotia Caregiver Benefit. For example, the 2008/2009 Community Health Survey estimated that Canada had 3.8 million unpaid family/friend caregivers aged 45 or older (Turner & Findly, 2012). This is evidence that a large portion of Canadian family/friend caregivers are middle-aged or over, and that those in this age group (45+) may be more likely to access tax credits and supports than those who are younger.

Another important factor relating to family/friend caregivers and accessing supportive services is the sex of the individual caregiver. Historically, women have taken on the majority of roles pertaining to care of the home and children, while men were more likely to participate in the paid workforce (Williams, 2005). The gender imbalance remains true for the caregivers of older adults. The 2012 General Social Survey revealed that more than half of all caregivers were female (54%) and that overall female caregivers provided more hours of care per week when compared to male caregivers (Sinha, 2013).

Grant, Amaratunga, Armstrong, Boscoe, Pederson & Wilson, (2004) found an even greater gender division, stating that nearly 80% of the in-home care workforce (both formal and informal) were women.

The second factor of the Andersen Newman Model is enabling factors, which include income, health insurance coverage, and the presence and availability of a caregiver (Andersen & Newman, 1973). To state it simply, "enabling factors are factors that affect the availability and accessibility of resources/services" (Hawkins, 2005, p. 18). In regard to income, it was previously mentioned that Manitoba offers a tax credit that is fully refundable. This means that a person may qualify to receive the Primary Caregiver Tax Credit regardless of whether or not they pay income taxes. This form of tax credit has the potential to benefit a broad range of family/friend caregivers, as it does not discriminate based on income. This is important, considering that approximately half of family/friend caregivers are also members of the paid workforce, and that many family/friend caregivers leave paid employment to provide informal care (Fast, Williamson, & Keating, 1999; Sinha, 2013). The Manitoban Tax Credit ensures that even those who have to leave employment to provide care can access and benefit from this support. Eligibility of caregivers to receive the Nova Scotia's Caregiver Benefit is based on the care recipient's income, stipulating that family/friend caregivers are unable to access the Caregiver Benefit if the income of the care receiver exceeds a specified amount. The Caregiver Benefit does not take into consideration whether the caregiver is able to work while providing care.

The final characteristic of the Andersen Newman Model is need factors, which is divided into perceived and evaluated needs. According to Strain (1990), need factors are

the strongest drivers of sudden service usage. Perceived illness relates to the way an individual perceives the severity of their own health status, and thus their need for care and support (Kang, 2007). Evaluated need is defined as a health need which has been determined by a health professional (Kang, 2007). This section of the Andersen Newman Model can be modified to apply to the family/friend caregiving relationship, especially considering that in some circumstances doctors or other professionals may recommend that an older adult have some assistance in order to remain in their home safely. In order for a caregiver to receive support, the person they are caring for may require an assessment from a health professional. For example, Manitoba has an extensive qualifying program that includes an assessment, which is based on the need of the care receiver and conducted by various health professionals such as physicians, occupational therapists, social workers and nurses (Government of Manitoba TAO, 2011). The ability of the family/friend caregiver to access the Primary Caregiver Tax Credit is dependent on whether the care receiver has been evaluated to require a certain level of assistance. This criteria of inclusion has the potential to leave out a number of family/friend caregivers who could greatly benefit from the support.

Chapter 3: Literature Review

Rationale for Supporting Caregivers

Those born after the Second World War between 1946 and 1964 have become known as the "Baby Boomer Generation", because of the spike (or boom) in the birth rate during this time. This significant demographic change was accompanied by policy shifts, which were meant to accommodate the needs of this large group of young people. Just as policy changes were needed when the baby boom was identified, it is now recognized that further policy shifts are needed to accommodate their changing needs as they age. As the baby boomers continue to age, they will require some form of assistance to remain in their homes. In order for governments to avoid the high cost associated with publicly-funded institutions, it is of vital importance that policies are implemented that support family/friend caregivers, so that they can in turn support this aging population.

For this analysis, family/friend caregivers are identified as a person "who provides support, care and assistance, without pay, to an adult or child who is in need of support due to a disability, mental or chronic illness, life-threatening illness or temporary difficulty" (Keefe, 2011, p. 4). Family/friend caregivers can make it possible for older adults in need of support to stay out of expensive long-term care facilities longer into the aging process or in some circumstances, all together. If a person were not cared for by a family/friend caregiver, the alternative would be to enter a publicly subsidized facility where health care costs fall to the responsibility of their provincial/ territorial government. Given the current economic climate in Canada, the idea that a growing number of older adults may soon enter publicly subsidized institutions cannot be ignored.

According to Hollander, Liu & Chappell (2009) "a reasonably conservative estimate of the imputed economic contribution of unpaid caregivers for Canada for 2009 would be $25-$26 billion" (p. 48). As our population continues to age steadily, and older people exceed the number of younger able-bodied potential caregivers, Canadian governments may take on more of the costs and responsibilities of caring for these older adults.

Without the use of family/friend caregivers, Canada's older population has the potential to overwhelm the health care system. According to popular media, the increasing numbers of older people entering publicly funded institutions have become known as the "grey tsunami". This refers to the idea that the senior population may soon use most of Canadian hospital beds and health care expenditures (Belluz, 2011). In order to avoid this, the creation of policies that invests in the lives of family/friend caregivers is needed. It is believed that such an investment would "improve access, be more cost-effective, reduce visits to hospitals and reduce pressure on long-term care facilities" (Belluz, 2011).

The costs of hospital stays vary by province and individual hospital, depending on the levels of technology available. The Canadian Institute for Health Information (2008) estimated that the average hospital stay in Canada costs approximately $6,983. This was found by analyzing 2.4 million hospitals stays across the country. It was discovered that about "45% of provincial and territorial governments' health care expenditure in 2009 was spent on seniors, yet this group accounts for only 14% of the population" (Canadian Institute for Health Information, 2008, p. 1). Seniors often stay in hospitals after their required treatments have finished, and are moved from an acute care bed to an alternate level of care (ALC) bed. "Nearly 85% of ALC patients are aged 65 or older and many,

35% are aged 85 and older" (CIHI, 2008, p. x). Such findings suggest that the Canadian senior population often continues to cost provincial and territorial governments, even when their treatment has finished. To help curb this issue, governments must put more emphasis and focus on community based supports and informal care.

There are both economic and social reasons for supporting family/friend caregivers. From a social perspective, it is important to support family/friend caregivers because their roles can, at times, be financially, physically and socially challenging. The Canadian Institute for Health Information (CIHI) (2008) reported that approximately 80% of care in the community is provided by informal family/friend caregivers. As our population continues to age, people may avoid entering a family/friend caregiving relationship if they see that past family/friend caregivers did not receive proper support from their government and communities.

Providing informal care to a loved one at home can be both a rewarding and challenging task to take on. With this task, there are often very positive benefits to both the caregiver and care receiver. There are however, challenges and costs related to caregiving relationships, particularly those experienced by the caregiver, which can include emotional and financial costs or strain. Experiencing such costs and challenges can lead to what is often called 'caregiver burden'. Caregiver burden according to Marina Bastawrous (2012) encompasses "the physical, psychological, emotional, social and financial stresses that individuals experience due to providing care" (p. 433; George & Gwyther, 1986).

As with any relationship, a caregiver may become emotionally invested in their role as a caregiver. The stresses often related to caregiving, can however have negative

consequences leading to a strain on the caregiver's emotional wellbeing. For example, in one study, Fast, Williamson & Keating (1999) discovered that "as many as 80% of informal elder care providers experience some degree of emotional strain" (p. 310). Such feelings may stem from the caregiver not feeling supported by their community or government which can lead to further emotional strain such as feelings of "resentment over their loss of independence and control" (Fast, et al., 1999, p. 310). If a caregiver experiences such feelings, this burden has the potential to "compromise the quality of care they are able to provide" (Bastawrous, 2012, p. 432).

Caregiving can also have financial consequences which can be linked to their formal employment. Among employed caregivers, the increased needs of the care recipient may mean having to reduce or relinquish their hours of paid employment in order to provide care. Reducing hours or relinquishing employment could lead to, "lost wages, benefits and opportunities such as training, attending conferences, extra projects and promotions, all of which could have led to an increased salary"(Fast et al., 1999, p. 312). In connection to employment CIHI (2011) found that 55% of women and 45% of men caregivers, who were able to maintain employment while providing care, revealed that their informal caring roles created negative consequences in their place of employment. These negative consequences came in the form of changing "work patterns or work hours, declining promotions, or job transfers, in order to accommodate their informal caregiving responsibilities" (CIHI, 2011, p. 77). This has the potential to lead to further financial stress that can affect the caregiver's family, along with the caregiving relationship.

Although caregiving can be both emotionally and financially taxing, it is important to note that can also have very positive benefits. Williams (2005) found that "more than 60% of caregivers felt they were giving back some of what life had given them, and 70% reported that their relationship with the elderly person strengthened" (p.18). Additionally, it has been found that "providing care to loved ones is something that is typically valued by caregivers and care recipients alike and that many caregivers would prefer to provide care themselves rather than have paid care providers come into their homes" (Hollander, Liu Chappel, 2009, p. 48).

Given that caregiving can be very positive, it is important that caregivers feel supported by their communities and governments, so that they experiences less instances of burden. In connection to this, a study of Dutch caregivers found that "people who feel more supported cope better with stress and difficult situations" (Tolkacheva, Broese Van Groenou, De Boer & Van Tilburg, 2010, p. 34). This may also prove to be true for Canadian family/friend caregivers. For this reason, it is important for governments to support caregivers so that they may continue in their role as a family/friend caregiver and help their care recipient remain in the comfort of their own home much longer.

Policy Domains Involved in Supporting Caregivers

According to Martin-Matthews, A., Tamblyn, R., Keefe, J., & Gillis, M. (2009), "Canada has made little progress in an integrated policy approach to addressing caregiver issues" (p. 188). Although it has been difficult for policy makers and politicians to come to a consensus regarding what direction caregiver policies should take (Martin-Matthews et al.), there are a number of policy domains in Canada that were (whether directly or

indirectly), implemented to support Canadian family and friend caregivers, so that they may in turn further assist their care receiver. These policy domains include: 1) Policies of direct services to the Care recipient such as Long Term Care and Home Care that a caregivers may turn to when the level of care required by the care receiver exceeds what can be provided in the home; 2) Services directed specifically to the caregiver such as including respite services as part of home care and education/training policies that support community based support groups, social supports; 3) employment related policies, such as the Compassionate Care Benefit or pensions that caregivers pay into during the duration of their employment; and 4) income security policies such as financial support programs, which is the primary focus of this research.

Direct services for care recipients.

Home care**.** All provinces and territories have a public home care program which upon assessment provides eligible care recipients with access to support to enable them to remain in their own home. Although eligibility and costs for these services vary across all jurisdictions, almost all have personal care and homemaking services to assist with activities of daily living and instrumental activities such as meal preparation and housekeeping. Nursing services, when assessed, are also available at no cost to the client (Keefe, Ogilvie, Stevens, MacPherson & Stoddart, 2014). These services, while directed to the care recipient, may provide some relief to the caregiver and enable them to be connected to other services that may be of assistance in their caregiving role.

Long-term care. Some family/friend caregivers may be involved in a caregiving relationship in which the care required by the care receiver exceeds what the caregiver

can provide to them. This may occur after hospital treatment for an acute care incident, if long-term care beds are available or if community supports for family/friend caregivers are inadequate. The costs associated with stays in long-term care facilities are not covered by the Canada Health Act and thus vary greatly by province and territory (CBC News, 2013). The costs of Personal Care Home beds in Manitoba are "shared by the provincial government (Manitoba Health) and the client who needs the service. Manitoba Health pays the majority of health care costs through the regional health authorities" (Government of Manitoba, 2013). The remainder of the cost is covered by the client and based on their net income. For example, a single person with an income (in 2011) of $16,231 will have a daily charge for personal care services of $35.00 with a disposable income of $288.00 per month (Government of Manitoba, 2013).

As part of their continuing care strategy, the province of Nova Scotia committed to building 1,320 new long term care beds "on top of a number of projects already taking place" (Government of Nova Scotia, 2011). Similar to Manitoba, Nova Scotia residents of approved facilities "pay the 'accommodation' portion of their long term care costs" (Government of Nova Scotia, 2011). While the provincial government is responsible for the health care costs, shelter or accommodation costs are at least partially covered by the resident. As of November 1, 2013, the Standard Accommodation charges for a nursing home in Nova Scotia was $102.50 per day (Government of Nova Scotia, 2012), with a total per diem cost of $248.59, (Nova Scotia Department of Health and Wellness, personal communication, 2014), where the health portion is covered by the government. Effective as of November 1, 2012, single Nova Scotia long-term care residents are able to retain "at least 15% of their annual income…and will not be left with an amount below

$3,042.00 a year" (Government of Nova Scotia, 2012). In realizing that a portion of the costs associated with long term care are covered by the provincial government, it must also be recognized that governments will face financial hardships as the population continues to age. For this reason, it is financially beneficial to invest in supporting community-based initiatives and family/friend caregivers, who can help older adults in need of assistance, remain in their own homes.

Direct services that support family/friend caregivers.

Respite care. According to the Victoria Order of Nurses, "respite care is the break that caregivers get by allowing someone else to temporarily take over some of their caregiving duties" (VON, 2009). This is meant to help alleviate some of the stresses that can be related to being part of a caregiving relationship. It can also reduce feelings of isolation, often felt by the older adult being cared for (VON, 2009).

For most Canadians, utilizing respite care comes at a cost to the caregiver. According to Health Canada (2011), in some regions of Canada "there is no direct cost for in-home respite (Ontario, Manitoba, Yukon, Northwest Territories, Nunavut, First Nations and Inuit Health Branch programs, Veterans Affairs Canada programs)". Other places take into account income or income plus assets to determine eligibility and the cost to be covered by the family (Health Canada, 2011). Low-income care recipients in these jurisdictions may qualify to have their costs covered, such as in Nova Scotia (Health Canada, 2011). Other provinces such as Saskatchewan and Alberta have a monthly cap "on the amount paid by the client…after which the public system covers costs" (Health Canada, 2011).

Although respite care provides many benefits to both the caregiver and care recipients, the costs associated with respite care may be unattainable for many caregiving relationships. According to Health Canada (2011) “many seniors or others on limited incomes have stated that the amounts they are required to pay for in-home respite or a respite bed in a facility, present an insurmountable financial barrier and they must do without respite”. With that, Health Canada (2011) stated that “disparities in access to respite based on income both within jurisdiction and between jurisdictions are subjects for ongoing study and discussions on equality of access to services in Canada”.

Education/information**.** Direct services to caregivers also include education, providing information and counseling. Caregivers can find beneficial social and educational supports through local non-profit organizations, such as Caregivers Nova Scotia. This can also be accomplished by accessing information on a plethora of web-based information resources, such as through the Canadian Caregiver Coalition and the member organizations that support this initiative. Family/friend caregivers surveyed in Manitoba “identified a focus on caregiving self-care supports, including accessible counseling and emotional support, support groups, and easier access to preventive and health promoting services, as an important government priority” (Funk, 2012, p. 20). Although no direct financial assistance is provided through educational and social supports, these types of supports may provide educational and coping tools to help family/friend caregivers deal with difficult and stressful situations related to caregiving. Additionally all provinces have publically-funded home care programs in addition to their long term care facilities.

Labour Policies for Caregivers: Compassionate Care Benefit

Labour policies that may be available to employed caregivers include a short term paid leave for someone caring for a person in palliative care, for example the Federal Government's Compassionate Care Benefit. According to Service Canada (2013), "compassionate care benefits are Employment Insurance (EI) benefits paid to people who have been away from work temporarily, to provide care or support to a family member who is gravely ill and who has a significant risk of death within 26 weeks (six months). A maximum of six weeks of compassionate care benefits may be paid to eligible people". In order to qualify, a person must be able to show that their earnings have decreased by more than 40 percent and that they "have accumulated 600 insured hours of work in the last 52 weeks, or since the start of your last claim" (Service Canada, 2014). Unlike the two provincial supports of interest, compassionate care benefits may be shared among family members who have also applied for the benefit. An eligible caregiver can receive a "basic benefit of 55 percent of their average insurable earnings, up to a yearly maximum insurable amount ($48,600 in 2014). This means that in 2013, a caregiver could receive a maximum payment of $513 per week" (Service Canada 2014). Receiving a maximum of $513 per week while providing end of life care to a loved one, could help decrease some of the financial stresses normally associated with this type of care. However, there may be circumstances where the care recipient lives longer than the 6 weeks allocated to the compassionate care benefits. As a person comes closer to death, their needs may increase and they may require more assistance. In such a situation, the care provider may have to choose to decrease their paid hours of work or stop working all together. Such a situation could create financial difficulties for the caregiver.

Income Security Policies: Financial Support for Caregivers

Within the policy domain of income security, the provision of financial support for caregivers is an important concern that has come to be recognized by Canadian federal and provincial governments. Financial support for caregivers, the main focus of this analysis, may fall under one of three categories, the first being direct financial support policies, which provide the caregiver a wage, allowance or voucher for their work (Keefe & Rajnovich, 2007). This is the type of support offered through Nova Scotia's Caregiver Benefit and will be one of the focuses of analysis. Secondly, there are indirect financial support policies also known as tax relief or pension security, which is a form of delayed monetary support. This type of assistance is found in the province of Manitoba through their fully refundable Primary Caregiver Tax Credit. Lastly, there are public labor policies, which allow a caregiver to leave work in order to provide care, while still receiving a portion of their income (Keefe & Rajnovich, 2007). This may be provided through an employment insurance initiative, such as the Compassionate Care Benefit, which is provided by the federal government. This particular benefit offers only 6 weeks of Employment Insurance to a caregiver, caring for someone toward the end of the care receiver's life (Service Canada, 2013). However, this benefit provides no financial assistance to caregivers during the beginning stages of the caregiving relationship.

One seemingly obvious form of financial support for caregivers would be for them to be provided with some type of allowance, either from a form of government support where money would be given to the care receiver to pay the caregiver, or given directly to the caregiver (Keefe & Rajnovich, 2007). This type of direct payment "can

provide autonomy and flexibility for both caregivers and care receivers, to decide how to use the funds" (Keefe & Rajnovich, 2007 p. 85). This approach is rare in Canada, the exception being Nova Scotia.

Some critics find controversy behind the idea of caregivers and care receivers being in a relationship that involves payment, as they believe it may change the dynamic and expectations of those involved. It may cause those involved to move away from the societal expectation that family members should provide care (Keefe & Rajnovich, 2007). Some critics believe that adding payment between the caregiver and care receiver could lead to abuse of the care receivers, while others, argue that "there is no evidence to support this connection" (Keefe & Rajnovich 2007, p. 80). In fact, it has been argued that direct payment policies "can change the caring relationship in positive ways" (Keefe & Rajnovich, 2007 p. 80). This type of direct support policy has yet to become the preferred type of policy to implement when it comes to supporting family/friend caregivers but it is possible that as our population continues to age and the needs of caregivers change, this type of policy may become more popular.

The Canadian taxation system (both federal and provincial) is a complex system that encompasses three goals meant to create a better and stronger Canada. These goals include transferring "resources from the private to the public sector, to distribute the cost of government fairly by income classes and among people in approximately the same economic circumstances, and to promote economic growth, stability and efficiency" (Pechman, 1987, p. 5). The goals of the taxation system are primarily economic in scope, yet they are increasingly used to achieve better social outcomes. For example, supporting and recognizing family/friend caregivers does not fit into one of these three categories

but in recent years federal and provincial governments have used their taxation systems to recognize the work of family/friend caregivers. This highlights the fact that using the taxation system in such a way is not consistent with the original intent of the Canadian taxation system. This raises the question of whether or not it is an adequate method of recognizing and supporting the vitally important work of family/friend caregivers.

Tax relief and aid for family/friend caregivers may come in the form of tax credits, deductions and exemptions. In using one of these three methods, the tax system may be used as a way to reduce poverty by limiting the amount of money that governments are able to take from their citizens (Pankratz, 2008). Some argue that a tax credit, sometimes known as a voucher, is more beneficial than a tax deduction as they are directed towards "lower-income or high-risk people who need it most, while a deduction provides more subsidy to those with higher taxable incomes" (Pauly & Hoff, 2002, p. 2). Additionally, a credit may be any specified amount, "while a deduction makes the financial assistance proportional to the person's marginal tax rate" (Pauly & Hoff, 2002, p. 2). Manitoba is one of only three Canadian provinces that offer its family/friend caregivers a fully refundable tax credit meant to recognize and support them with their caregiving endeavors. Nova Scotia offers its family/friend caregivers a monthly benefit meant to offset the expenses they incur while caregiving. These two provinces have chosen different, yet distinctly identifiable approaches to support caregivers.

Although these two supports are different, in that one is a direct financial support policy and the other is a delayed financial support policy, they have been chosen because their general nature and goals are very similar. These supports are intended to help sustain and support the caregiving relationship, particularly by recognizing the

contributions of the family/friend caregiver. Population size was also considered when choosing the two caregiver support policies, as the two provinces are fairly close in size. In 2012 Statistics Canada reported that Nova Scotia had a population of 948.7 thousand and that Manitoba had a population of 1.2 million (Statistics Canada, 2013). Additionally, these two provinces are fairly innovative in having implemented supports, as most other provinces have yet to implement anything similar. These two supports are also similar in that they were introduced in the same year 2009, and both revised these supports in 2011. For example, the amount provided through the Primary Caregiver Tax Credit increased and the Caregiver Benefit had a name change, formally the Caregiver Allowance.

Canadian governments both federal and provincial/territorial who have yet to implement financial supports or forms of recognition for family/friend caregivers can look to other countries such as the United Kingdom and Australia to improve existing supports and/or find inspiration for the creation of new supports. For example, Rummery and Fine (2012) refer to a 'justice' model of care which "translates neatly into the core concerns of social policy: the well-being of citizens and the outcomes of policy for individual citizens, communities and the state" (2012, p. 326). Care being an issue related to justice has "been central to the approach adopted to care and to research on caregiving in the UK, Northern Europe and Australia since the late 1970s (Barnes 2001; Fine 2007) where responding to the isolation, poverty and social exclusion of primary caregivers has become central to civic campaigns for the recognition informal care" (Rummery & Fine, 2012, p. 326). This has led to the "creation and expansion of vigorous carer movements and a number of corresponding gains in the recognition of the contributions of carers through benefits, payments and through acknowledgement in national legislation, such as

the Carers Recognition Bills in the UK and Australia" (Rummery & Fine, 2012, p. 326). Rummery & Fine (2012) state that countries in North America differ here in that more emphasis has been placed on "demonstrating the burden of care through the ever finer measurement of the psychological construct of 'caregiver burden' (Chappell and Reid 2002), the carers movement has been less influential and has struggled to develop a strong national presence" (Rummery and Fine, 2012, p. 326).

Although there are a number of supports for family/friend caregivers in Canada, such as those discussed in this analysis, there is certainly room for improvement. The policies of other countries including the UK and Australia can be looked at as an example of what could be used in Canada, in addition to existing supports. There is a notable gap that exists in Canadian knowledge regarding current financial support policies for family/friend caregivers. Despite attempts to support caregivers through various means (taxation, financial support, increased respite), little evidence exists pertaining to the overall financial benefits of such endeavors. For example, do such policies prolong caregiving relationships and/or save governments money? A narrowing of this knowledge gap could occur by conducting in-depth analyses of current financial supports for family/friend caregivers. This could help to determine if existing financial supports are beneficial and positive components of provincial budgets. This may then assist other provinces to decide to implement such supports.

Chapter 4: Methodology

Research Questions

The purpose of this study was to examine financial supports available to family/friend caregivers in the two identified provinces. The objective was to determine the rationale behind the implementation of the supports, to determine if these supports were effective and successful and to determine if other Canadian provinces should follow Manitoba and Nova Scotia's lead in implementing similar forms of support and recognition. Two research questions were imbedded in the original approach of this analysis:

Question 1: "What were the driving forces behind the implementation of the Manitoba Primary Caregiver Tax Credit and the Nova Scotia Caregiver Benefit and what are the benefits and limitations to having such a support";

Question 2: "What are the shared characteristics among the family/friend caregivers who are accessing these supports?"

Case Studies

In an attempt to properly address the above-mentioned research questions, multiple research methods were used in order to arrive at a comprehensive understanding of the two support policies. This study primarily consisted of two separate case studies that addressed the Manitoba Primary Caregiver Tax Credit and the Nova Scotia Caregiver Benefit. Case study analysis was chosen as the primary method of analysis, as it

facilitates "exploration of a phenomenon within its context using a variety of data sources" (Baxter & Jack, 2008, p. 544). The use of multiple sources of data "ensures that the issue is not explored through one lens, but rather a variety of lenses which allows for multiple facets of the phenomenon to be revealed and understood" (Baxter & Jack, 2008, p. 544).

Case studies seek to explain the phenomenon of interest (Zucker, 2009). Several methods of analysis fell under the umbrella of the two case studies. These methods included key informant interviews, a secondary data analysis, an Evaluative Lens analysis and a review of relevant policy documents for each province. Using the case study method of analysis sought to address how the policies were developed, the rationale behind the implementation of the supports, challenges they have faced since implementation and their outcomes whether negative or positive.

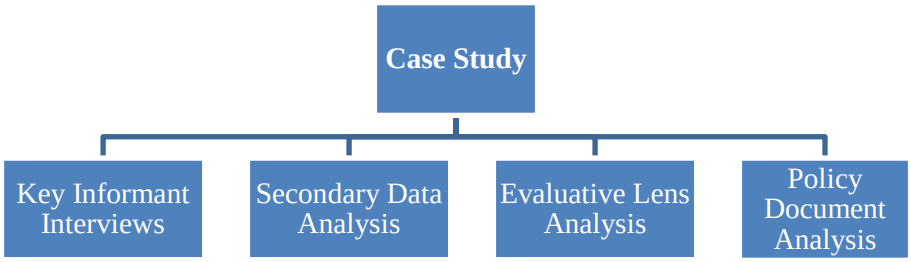

Figure 1: Case study analysis table.

The Evaluative Lens as utilized by Keefe and Fancey (1999) considers the equity, adequacy, suitability, and sustainability of a policy. Equity according to Keefe and Fancey (1999), asks "how fairly and impartially are benefits available to all caregivers and care receivers? Do certain types of policies have greater benefits for certain socioeconomic classes? Are they universally available both in terms of geography as well as eligibility criteria?" (p. 194). Adequacy, according to Keefe and Fancey (1999) asks "to what extent do the provisions meet certain requirements; e.g. should the program maintain a minimum standard of living, or be sufficient to compensate for lost employment?" (p. 194). Suitability (or Appropriateness), according to Keefe and Fancey (1999), looks at the following, "are the services appropriate or compatible with the client's needs? Does the program meet the care needs of the care receivers and/or caregiver?" (194). Finally, sustainability looks at whether or not "the programs or services help to continue the care giving relationship? Would the person being cared for be placed in an institution earlier if the program or support was not available?" (Keefe & Fancey, 1999, p. 195).

Additionally the Caregiver Policy Lens as described by MacCourt and Krawczy and the Caregiver Toolkit (2012) was used to help inform the analysis of the two supports. MacCourt and Krawczy (2012) have found that "most public policies have been developed without taking into account the needs that affect caregivers of older adults. Their contribution has been mostly overlooked, largely under-valued and even undermined" (p. 5). For this reason, the questions asked in this policy lens were

considered and used to frame a further understanding of the support policies as they pertain to the Evaluative Lens.

Sample/ Key Informant Interviews

As a means of gaining a further understanding of the rationale behind the implementation of the two support policies, and any issues that arose with the implementation a series of N=10 key informant interviews were conducted. These interviews were conducted with people who were instrumental in creating/implementing the supports which included senior policy analysts, advocates/caregiver organization representatives and politicians. Questions and themes adapted from Keefe, Fancey and White (2005) were used throughout the key informant interviews. These questions addressed the following: (See Appendix one).

1. Rationale/Objective of the caregiver policy
2. Administration infrastructure
3. Utilization patterns/profiles
4. Assessment/case management process
5. Program financing
6. Integration with direct services for caregivers
7. Ethical considerations/debates
8. Program evaluation

In order to begin this analysis and to obtain the desired information and data, initial contact with potential key informants was made through the thesis advisor. A list of potential key informants had been made previously by the researcher, by conducting

Google searches of the two provincial governments. Key informants often suggested other potential contacts, which were then added to a contact list. The list of potential key informants were sent an introductory letter from the Thesis Advisor, on the researcher's behalf. This letter highlighted the intent of the analysis and invited them to participate in the research project. When a key informant agreed to participate, by contacting the researcher, an informed consent form outlining all the risks associated with the project was issued. When requested, the interview guide questions were also sent to the key informant to provide a better understanding of the information that was desired. Email was chosen as the initial means of communication due to the researcher's geographical location and inability to travel to Manitoba to conduct that series of interviews. Telephone conversations were then used to conduct the interviews. These phone calls ranged in length from 20 minutes to over one hour.

Through conducting key informant interviews, benefits and challenges in regard to implementing these two types of supports were uncovered. Some key informants were also able to speak to the difference these supports have made for family/friend caregivers and how the supports could be improved. The objective of analyzing the key informant interviews was to determine the rationale behind the implementation of the policies, and to determine whether or not the Primary Caregiver Tax Credit and the Caregiver Benefit are perceived to be successful and effective. An additional objective was to determine if other provinces/territories or the Federal Government should implement similar initiatives. Once the data from the key informant interviews from each province were gathered, they were read through, analyzed and compared to determine if there were

similarities among the responses. These responses were then used to address the questions that fall under the evaluative lens.

Key informant interview participants from Nova Scotia included;[1]

1) Policy Expert (PE) 1, Susan Stevens, Director, System Planning Continuing Care Branch Department of Health and Wellness,
2) Policy Expert (PE) 2 Carolyn Maxwell Director, Liaison and Service Support Continuing Care Branch Department of Health and Wellness,
3) Government Representative 1, Chuck Porter, Hants West MLA, Health Critic in PC shadow cabinet (HC),
4) Government Representative 2, Hon. Leo Glavine, Minister of Health and Wellness (MHW) and;
5) Expert Caregiver Representative (ECR) Angus Campbell, Executive Director of Caregivers Nova Scotia along with colleague Lynn Butler.
6) Dual Policy Expert (DPE) Bonnie Schroeder (independent consultant), Social Program and Policy Consultant was able to speak to both the Nova Scotia Caregiver Benefit and the Manitoba Primary Caregiver Benefit.

Key informants from Manitoba included;

[1] There were many other consultations that occurred with experts in the field of caregiver policies who were not included as key informants. For example, Janice Keefe and Pamela Fancey, two of the thesis committee members and experts in the area of financial consultation were contacted to review some of their research from 1996-2010 in this area. Their research provided insight into the challenges and opportunities of introducing this type of income security policy for caregivers. See references.

1) Senior's Policy Expert (SPE) Shannon Kohler Consultant for Manitoba Healthy Living & Seniors, Seniors & Healthy Aging Secretariat,
2) Academic Expert (AE), Kerstin Roger Assistant Professor, University of Manitoba Department of Family Social Sciences,
3) Taxation Expert (TE), Michael Rennie, Senior Taxation Analyst Fiscal Research Division, Manitoba Finance, and;
4) Policy Expert (PE) Roxie Eyer Consultant, Continuing Care Branch Manitoba Health.

Consent. When a key informant responded to the initial invitation to participate in the analysis, an informed consent form was sent to them, outlining the rationale behind the research and how their responses to the questionnaire would be used. It was noted on the informed consent form that their personal opinion of the supports was not required; rather it was the opinion of the organization that they represent, that was desired. This helped to avoid any conflict of interest that could arise. Because information shared by the key informants was not confidential, the identities of the key informants were used, unless they otherwise indicated on their informed consent form. However, all key informants gave permission to use their names and direct quotations.

Secondary Data Analysis

Lastly, a secondary data analysis of administrative data originally collected by the provinces of Manitoba and Nova Scotia was conducted. The original variables of interest that were requested included the age of the caregiver and care receiver, the sex of the caregiver and care receiver, the income of the caregiver and care receiver and whether they live in an urban or rural area. The original purpose of utilizing these variables was to

determine whether or not there have been shared characteristics among family/friend caregivers who have accessed these supports since their introductions in 2009.

For Manitoba, Roxie Eyre, policy expert and Consultant at the Continuing Care Branch, was asked and agreed to request the above-mentioned variables. In requesting this data, it was determined that the province does not collect most of the desired variables because eligibility is not based on age, sex or income. Eligibility is "defined by assessed care need and residency within a Regional Health Authority" (Roxie Eyre, personal communication, 2013). The location of where the care is provided "is not specifically collected but is collected by Regional Health Authority" (Roxie Eyre, personal communication 2013). Lastly, the reason why a caregiver's access to the tax credit was terminated is also not collected. This is because the province has no way to track termination of access to the credit. "The tax credit is obtained via self-declaration on an individual's annual tax return. There is no requirement for reassessment after a period of time" (Roxie Eyre, personal communication, 2013).

The breakdown of recipients by regional health authority was requested in order to give some indication of a rural/urban split. Below is a map identifying the 5 regional health authorities that make up the province of Manitoba. Not surprisingly, one of the more rural RHAs is the largest because of a sparser population and the most urban RHA is the smallest. The Winnipeg Regional Health Authority "can by and large be considered wholly urban. All the other regions have a rural/urban mix (mostly smaller communities)" (Roxie Eyre, personal communication, 2013).

The data from Manitoba that was provided showed the number of applicants in each of the five Regional Health Authorities in the province, between 2009 and October

15, 2013. Further data was later provided that showed the breakdown of applicants who were Home Care Clients and Non Home Care Clients. Four of the Regional Health Authority applicant numbers were added together, to provide a total number of applicants in rural parts of the province. Population data for Manitoba was accessed online through population reports that were prepared by Manitoba Health, for the years of interest. Populations of the Regional Health Authorities were added to show the difference in population size of the predetermined rural and urban areas of the province.

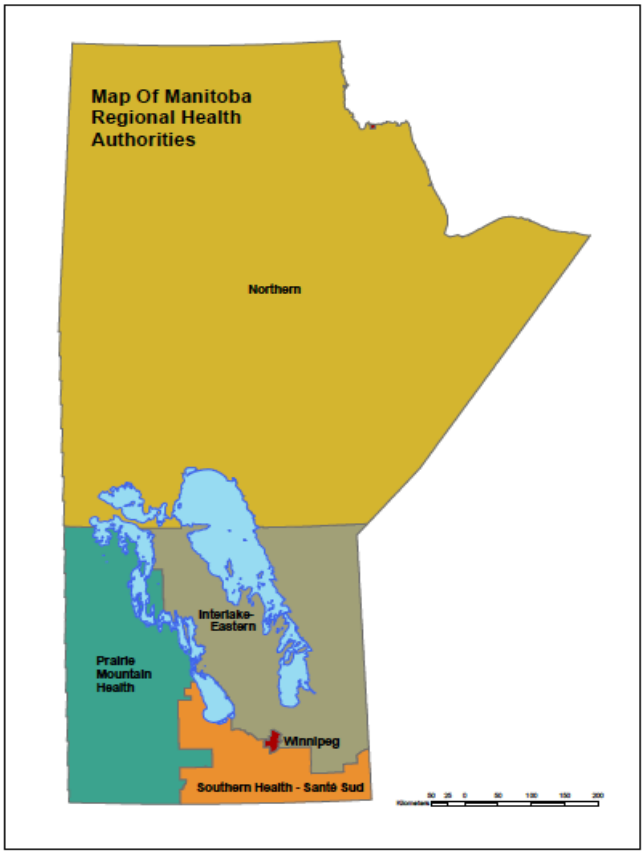

Figure 2: Manitoba Health (2013). Map of Manitoba Regional Health Authorities. Source: Government of Manitoba. 2013.

Nova Scotia is separated into 9 District Health Authorities (DHA). (see Figure 2). Data pertaining to the characteristics of Nova Scotia caregivers and care recipients was

also requested. Because eligibility for the Nova Scotia Caregiver Benefit is based on characteristics of the care recipient, characteristics of the caregiver are limited. The Nova Scotia Department of Health and Wellness was able to provide an extensive data set that outlined the characteristics of all of the benefit recipients since the implementation of the program. This particular data set included both clients (care recipients) whose eligibility for the benefit continues and data for clients who are no longer eligible for the benefit either because they have died or they have entered a long-term care facility.

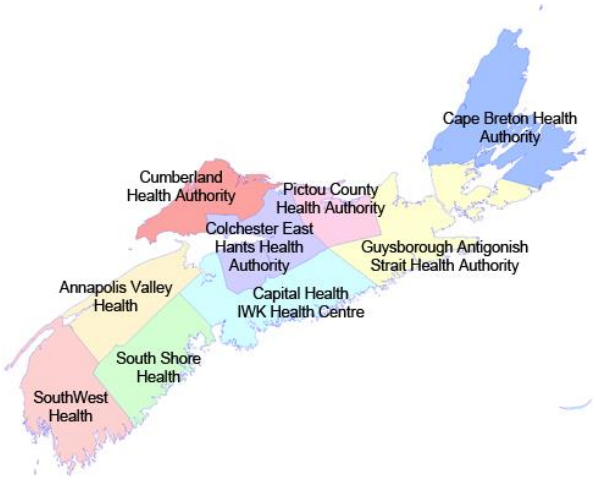

Figure 3: Government of Nova Scotia (2013) District Health Authorities.
Source: Nova Scotia Department of Health and Wellness. 2013.

The secondary data that was provided by the province of Nova Scotia, included information pertaining to 2,854 caregiving relationships from program launch to December 1, 2013. This data was analyzed using the Statistical Package for the Social Science (SPSS). Several sub-samples of the overall data set have been used to analyze various points of interest.

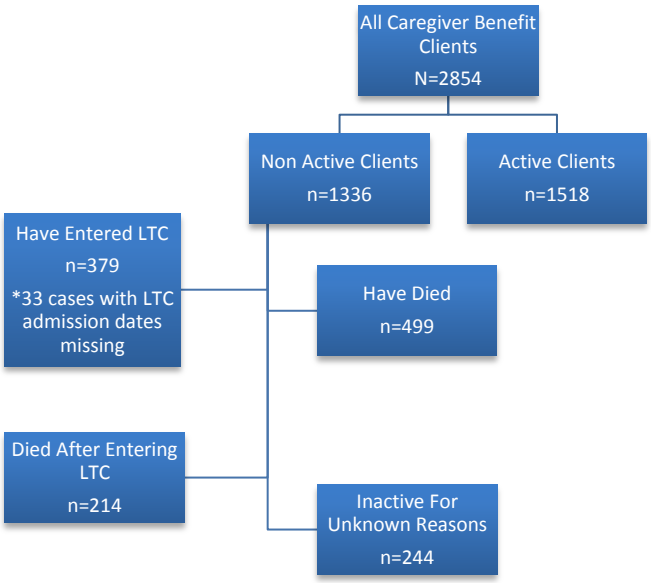

Figure 4: NS Caregiver Benefit Data (Active and Inactive), by Reason for Inactivity (as of December 1, 2013)

Variables and analysis. The data was broken down in several extensive categories, some of which were chosen for this analysis, and were analyzed using bi-variate cross tabulation analyses. The 'status' variable was used to determine the number of active and inactive clients (see Figure 3). This was found by running a frequency of the variable. The 'death date' variable was used to determine the number of clients who have died; this was also acquired by running a frequency. A frequency was also run on the 'DHA' variable to determine the number of clients in each District Health Authority. The 'gender' and 'age at enrollment' variables were also considered, but had been

previously manipulated by the Department of Health and Wellness to show the mean ages and frequencies of males and females. Lastly, an Analysis of Variance (ANOVA) was used to compare the weekly hours of care provided by the 4 identified categories of caregivers.

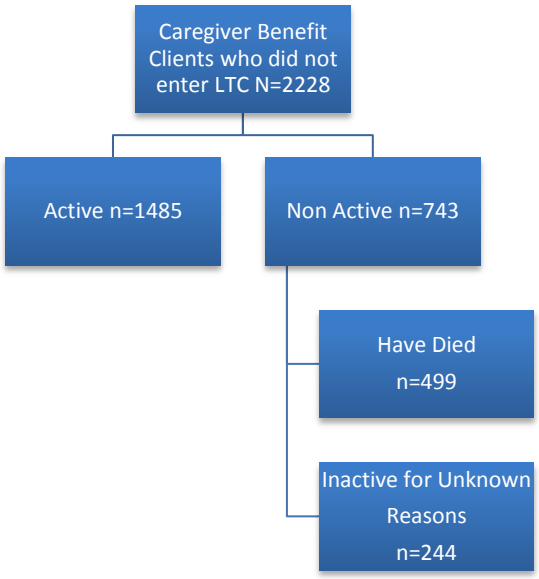

Figure 5: Sub Sample of Nova Scotia Caregiver Benefit Clients Who Did Not Enter Long Term Care, by Reason (as of December 1, 2013)

The caregivers 'start date' and 'end effective date' were analyzed using the Date and Time Wizard to determine how many months the caregiver received the benefit. The mean of this was then determined by using Descriptive Statistics. This method was also used to calculate the difference between the 'start date' and 'LTCadmission date' as well as to calculate the difference between 'LTCadmission' and 'death date'. Figure 4 provides an overview of those NS Caregiver Benefit Clients whose care recipient never

entered LTC – The group who are inactive and have died are of particular interest (n=499) as these cases received the Caregiver Benefit and were never admitted to LTC.

Chapter 5: Results

Manitoba Primary Caregiver Tax Credit Background

Manitoban family/friend caregivers officially received recognition by their government in 2011. The provincial government introduced the Manitoba Caregiver Recognition Act, which sought to "establish a legislative framework to increase awareness and recognition of Manitoba's informal or family caregivers, and acknowledge their valuable contribution to society" (Government of Manitoba, 2011). In addition to implementing this act, the government increased their Primary Caregiver Tax Credit, which was implemented in 2009, by 25% (Government of Manitoba, 2011). These two initiatives are viewed as positive since the 2007 General Social Survey uncovered that about "one-fifth of Manitobans aged 45 and over, reported providing assistance to a senior experiencing physical or other limitations due to long-term health conditions" (Government of Manitoba, 2011).

The Primary Caregiver Tax Credit, which was implemented in January of 2009, is a fully refundable tax credit, (meaning that a person may be eligible to receive it regardless of whether they are paying income taxes), offers $1,275 per care recipient, annually, to caregivers with up to 3 care recipients in their care (Manitoba Tax Assistance Office, 2011). The tax credit is meant to "help cover caregiver expenses; this could include respite care, taking the client shopping, to medical appointments or on recreational outings" (Manitoba Tax Assistance Office, 2011). In order to qualify for the Primary Caregiver Tax Credit, the caregiver must first complete a "three-month qualifying period" (Manitoba Tax Assistance Office, 2011). Additionally, the "caregiver

must be a resident of Manitoba on December 31, be identified by the person receiving care (or their parent if the person receiving care is under 18) and must not be paid to provide care to this person" (Manitoba Tax Assistance Office, 2011). The primary caregiver is not required to live with the person they are caring for and is not required to be a relative of the person receiving care (Manitoba Tax Assistance Office, 2011).

A care receiver must also meet certain eligibility criteria in order for their caregiver to qualify for the Primary Caregiver Tax Credit. For example, the care receiver "must be assessed based at a Level 2 or higher under the Manitoba Home Care Guidelines" (Manitoba Tax Assistance Office, 2011). This level of care is based on "the amount and type of care required for tasks like bathing, dressing, eating meals, mobility and receiving medical care" (Manitoba Tax Assistance Office, 2011). People not receiving assistance through the Manitoba Home Care Program may also receive an assessment for the Primary Caregiver Tax Credit, which is conducted by licensed or registered health professionals (Manitoba Tax Assistance Office, 2011).

Manitoba Primary Caregiver Tax Credit Applicants

The data in Table 1 represents the number of applications in each Regional Health Authority by year (not ongoing credit recipients).

Table 1: Manitoba Health Continuing Care Branch Primary Caregiver Tax Credit Number of Applications by Region (2009-2013)

Regional Health Authority	2009	2010	2011	2012	2013*	Total
Prairie Mountain	108	425	397	283	421	**1,634**
Northern	2	39	47	33	44	**165**
Southern Health	19	244	295	184	295	**1,037**
Interlake-Eastern	64	402	243	171	288	**1,168**
WRHA	318	1,929	1,730	1,731	1,503	**7,211**
Total no. of Applicants	511	3,039	2,712	2,402	2,551	**11,215**

*As of October 15, 2013

Source: Manitoba Continuing Care Branch, 2013. *Manitoba Health.*

"Once a person has applied and has been deemed eligible, they would apply for the credit via the income tax process, with no further regional/departmental involvement" (Roxie Eyre, personal communication 2013). Manitoba saw an initial increase to the number of applications for the Primary Caregiver Tax Credit after the first year, as the number of home care clients increased. "While home care client numbers are increasing, there is a point where most existing clients who are able to apply, have already done so. The growth comes as a result of new Home Care clients" (Roxie Eyre, personal communication, 2013). In addition, the number of applicants who are not home care clients (equivalency applicants) is also increasing steadily (Roxie Eyre, personal communication, 2013). Table 2 depicts the numbers of home care clients and non-home care client applicants of the tax credit from 2009-October 15, 2013.

Table 2: Primary Caregiver Tax Credit Applications by Region from 2009 to Oct. 15, 2013 for RHA Home Care & Non-RHA (equivalency clients) Home Care

Year	2009	2010	2011	2012	2013*	Total
RHA-HC	386	1,938	1,424	1,198	1,068	**6,014**
Non RHA-HC	125	1,101	1,288	1,204	1,483	**5,201**
Total no. of Applications	**511**	**3,039**	**2,712**	**2,402**	**2,551**	**11,215**

*As of October 15, 2013
Source: Manitoba Continuing Care Branch, 2013.

Because the Regional Health Authorities cannot be identified as rural or urban, two groups of RHAs were chosen for comparison. The WRHA was compared to all of the other RHAs. This was chosen because the WRHA is identified as the most urban Regional Health Authority in Manitoba as it contains the province's largest urban center, Winnipeg. The other RHAs are smaller in terms of population and are more rural or have an urban/rural mix. Table 3 gives an example of how the numbers of people receiving the tax credit are dispersed throughout the province.

Table 3: Number of Applications by Region and Proportion of Population (2009-2013)						
Regional Health Authority	**2009**	**2010**	**2011**	**2012**	**2013**	**Total**
WRHA applications	318	1,929	1,730	1,731	1,503	**7,211**
Population of WRHA	688,533	698,195	710,789	723,491	N/A	N/A
Per 100,000	46.2	276.3	243.4	239.3	N/A	N/A
All other RHA applications (rural)	193	1,110	982	671	1,048	**4,004**
Population of all other RHA (rural)	525,870	532,075	539,695	547,897	N/A	N/A
Per 100,000	36.7	208.6	182.0	122.5	N/A	N/A
Total no. of all credit applications	**511**	**3,039**	**2,712**	**2,402**	**2,551**	**11,215**

*As of October 15, 2013
Source: Manitoba Continuing Care Branch, 2013; Manitoba Health and Healthy Living, 2009; Manitoba Health; 2011; Manitoba Health, 2010; Manitoba Health; 2012; Manitoba Continuing Care Branch, 2013.

Research identified that the number of applicants in the WRHA is much larger each year in comparison to all of the other RHAs combined. This is because the population is smaller in the more northern RHAs. Nevertheless it is interesting to note that the proportion of applicants has declined from 276.3 per 100,000 in 2010 to 239.3 in 2012. Since these data only represent "new applicants" this decline is not surprising as increases in the number of applicants each year are due to the increase in home care

clients and the number of equivalency applicants (those not receiving home care) who are applying. Table 2 showed that the number of applicants who are receiving Home Care are steadily declining, while the proportion of clients not receiving Home Care are increasing. This may be the result of eligible candidates having already applied for the Tax Credit, as previously mentioned by PE Roxie Eyre.

Appendix 2 outlines the populations of all of the RHAs in accordance with amalgamations that took place in 2012. In examining this information, it becomes more apparent as to why there are more people receiving the Primary Caregiver Benefit in the WHRA in comparison to all other RHAs. The population of the WRHA is significantly larger than all of the combined RHAs.

Nova Scotia Caregiver Benefit Background

Similar to Manitoba, caregivers and care receivers in Nova Scotia must also meet certain eligibility criteria outlined by the Nova Scotia government, in order to receive $400 per month through the Caregiver Benefit. This benefit was implemented in September 2009 to assist with the expenses of a caregiving relationship (Government of Nova Scotia Health and Wellness, 2013a). The caregiver is required to be a resident of Nova Scotia who is 19 years of age or older. During their caregiving relationship the caregiver must provide 20 or more hours of assistance each week and cannot be receiving any payment for this work. Additionally, they must "be willing to sign an agreement which defines the terms and conditions for receiving the caregiver benefit" (Government of Nova Scotia, 2013a).

Whether or not a caregiver can receive the Caregiver Benefit is highly dependent on the care receiver. They too must be a resident of Nova Scotia who is 19 years of age or older and who is part of a care relationship with a caregiver (Government of Nova Scotia 2013). The next regulation has the potential to make it very difficult for a caregiver to qualify for this benefit. The care receiver must "have a net annual income of $22,003 or less, if single, or a total net household income of $37,004 or less" (Government of Nova Scotia 2013). This means that if a person were caring for a dependent with a higher income, the caregiver would be ineligible for this benefit. Lastly, the care receiver must "have a care assessment completed by a Continuing Care Coordinator, indicating a very high level of impairment or disability requiring significant care over time" (Government of Nova Scotia 2013).

Nova Scotia Caregiver Benefit Recipients

Table 4 represents a comparison of the proportion of the populations (per 100,000) of Manitoba (applications by year, not ongoing recipients) and Nova Scotia (number of new applicants by year) who are accessing the supports. Noticeably Manitoba has a higher proportion of the population accessing the support each year. The proportional differences between rural and urban areas in Manitoba and Nova Scotia merit greater investigation. Are these differences, where Nova Scotia has a higher proportion of users in rural areas, and Manitoba has a higher proportion in urban areas, driven by the overall population differences in the province? For example, does the rural population of Manitoba include a greater population of First Nations and or younger people, and with that, does Nova Scotia have a higher proportion of older people?

Alternatively, these differences may be best explained by the differences in the eligibility criteria of the caregiver supports. Specifically the seemingly more restrictive income based criteria in Nova Scotia.

Table 4: Proportion of Nova Scotia Clients & Manitoba Applicants Accessing Caregiver Supports

Proportion of Nova Scotia Population Accessing Caregiver Tax Credit					
Year	**2009**	**2010**	**2011**	**2012**	**2013**
Total Number of Clients	516	413	585	544	796
Proportion per 100,000	**54.9**	**43.7**	**61.7**	**57.3**	N/A
Proportion of Manitoba Population Accessing Caregiver Tax Credit					
Total Number of Applicants	511	3,039	2,712	2,402	2,551
Proportion per 100,000	**42.1**	**247.0**	**216.9**	**200.7**	N/A

Source: Manitoba Continuing Care Branch, 2013; *Manitoba Health.* Government of Nova Scotia Department of Health & Wellness, 2013.

Table 5 represents the number of Caregiver Benefit clients in each District Health Authority since the program was implemented in 2009. This table demonstrates how Caregiver Benefit clients are dispersed throughout the province.

Table 5: Nova Scotia Health and Wellness Caregiver Benefit Clients: Total Number of New Clients by Region (2009-2013)

DHA Name & Number	2009*	2010	2011	2012	2013	Total
1) South Shore Health	46	34	52	42	82	**256**
2) South West Health	51	36	61	77	95	**320**
3) Annapolis Valley Health	46	45	58	31	59	**239**
4) Colchester East Hants	34	28	47	19	51	**179**
5) Cumberland Health	20	21	17	24	25	**107**
6) Pictou County Health	40	27	24	46	75	**212**
7) Guysborough Antigonish Strait Health	50	31	68	51	72	**272**
8) Cape Breton District Health	83	59	96	81	113	**432**
9) Capital Health	146	132	162	173	224	**837**
Total	516	413	585	544	796	**2854**

Source: Government of Nova Scotia, 2013.

Similar to data from Manitoba, the District Health Authorities in Nova Scotia are not necessarily labeled either urban or rural. The Capital Health, District Health Authority, includes the Maritime's largest urban center, Halifax. Halifax had a population of 390,329 in 2011 (Statistics Canada, 2013), much greater than any other area in the province. Given the differences in population size, Capital Health will be compared to all of the other 8 districts combined. Appendix 3 depicts the population of Nova Scotia as broken down by District Health Authority.

Table 6 illustrates that Capital Health is fairly close in population size to the combined populations of the other DHAs. In contrast to Manitoba, the combined areas of Nova Scotia have a higher proportion of people accessing the Benefit than the Capital Health DHA, which includes the province's largest city. This is noteworthy when recognizing that there are often more supports and resources in places that have greater populations. This may be directly related to Nova Scotia being one of the oldest provinces in Canada where many people of younger generations must leave rural areas in order to find work, leaving behind lower income, senior parents and relatives. For example, it was discovered that Halifax County, which is part of Capital Health is the youngest county in Nova Scotia. "Seniors made up 10.9% of Halifax County's population in 2007. In contrast 11 f the 18 counties have a senior population that represents 15% or more of the population" (Government of Nova Scotia, 2009, p. 2). These numbers are projected to increase in coming years. Because of the higher proportion of seniors and their lower average income outside Capital Health, they may be more likely to be eligible for the caregiver benefits. This information is interpreted as there being more seniors in areas outside Capital Health to access the support.

Table 6: Further Summary of Nova Scotia Provincial Population: Capital Health Compared to all Other DHAs						
District Health Authority	**2009**	**2010**	**2011**	**2012**	**2013**	**Total**
Capital Health Benefit clients	146	132	162	173	224	**837**
Population of Capital Health	420,165	426,185	431,692	435,643	N/A	N/A
Proportion Per 100,000	34.7	31.0	37.5	39.7	N/A	N/A
All other DHA clients (rural)	370	281	423	371	572	2017
Population of all other DHA (rural)	520,400	518,966	516,761	513,049	N/A	N/A
Per 100,000	71.1	54.1	81.9	72.3	N/A	N/A
Total number of Clients	**516**	**413**	**585**	**554**	**796**	**2,854**

Source: Government of Nova Scotia, 2014a; Government of Nova Scotia, 2013.

Nova Scotia Care Recipient Characteristics

The age and sex of the care recipients were available from the Nova Scotia data. Not surprisingly, given the higher incidence of chronic diseases and their longer life expectancy, there were more female care recipients than male (59.4% of all care recipients were female and 40.6% were male). When reviewing the active cases however, these numbers have shifted slightly in that care recipients receiving the Caregiver Benefits (as of December 1, 2013) are 56.7% female and 43.3% male.

The next point of interest for this analysis was the age of the care recipient. Since program launch, the average age of female recipients upon enrollment has been 74. On

average, DHA 5 (Cumberland Health Authority) has the oldest females at 80 years of age. DHA 7 (Guysborough Antigonish Strait Health Authority) had the oldest men (aged 69). Interestingly, in both cases the average age of women Caregiver Benefit clients is much higher than the average age of male clients. A factor contributing to these statistics is that women tend to live longer. The reason why the average age of men is much lower than females throughout all the DHAs may be accredited to a higher incidence of younger disabled people being eligible to become benefit clients. This is evident when considering the median age at enrollment is 76.5 with a Standard Deviation of 21.5 Table 7 summarizes the above information.

Table 7: Nova Scotia Caregiver Benefit Clients Sex & Average Age

Variable	All Caregiver Benefit Clients	Current Caregiver Benefit Clients (Dec 1, 2013)
Sex	59.4% Female	56.7% Female
	40.6% Male	43.3% Male
Average Age	74 Female	68 Female
	63 Male	57 Male

Source: Government of Nova Scotia, 2013.

A person's marital status can play a role in the amount of assistance and support they receive. As can be seen in Table 8, a high proportion of Caregiver Benefit clients (since program launch) were married (38.2%) and so it is not surprising that nearly a third

of the care being provided was done so by a spouse. Although accounting for only one in five clients, the proportion of never married individuals is much higher among Caregiver Benefit clients, when compared to the senior population of Nova Scotia. According to Statistics Canada (2014), in Nova Scotia, approximately 6% of the population 65 and older has never been married. Interestingly this is much lower than the 21% of Caregiver Benefit clients who have never married. This may account for the high number of other relatives (e.g. non-child/child-in-law or spouse) providing care (See Table 9).

Table 8: Nova Scotia Caregiver Benefit Clients from Program Launch to Dec. 1, 2013, by Marital Status

Variable	**All Caregiver Benefit Clients Since Program Launch**
Marital Status	38.2% Married
	32.0% Widowed
	1.3% Separated
	3.5% Divorced
	21.4% Never Married
	3.6% Other

Source: Government of Nova Scotia, 2013.

The relationship between the caregiver and care recipient is an extremely important one. A spouse, child or other family member may feel an obligation or responsibility to provide support and assistance when a loved one begins to require care. Since the program launch, the Nova Scotia Department of Health and Wellness has identified four different categories of caregivers. These categories include 940 spouses, 1169 child or child-in-laws, 673 other relatives and 72 friend/neighbours (see Table 9). An ANOVA was used to compare the weekly hours of care provided by the relationship between caregiver and care receiver. The four relationship categories

differed significantly in the weekly hours of care they provided, F(3,2850)=11.338, p=.000. It was found that care recipients with 'other relatives' (siblings, niece, nephew, etc.) as their care provider received the most care with an average of 68.20 hours per week[2]. This may be explained in part, by the percentage (21.4%) of people who were 'never married'. These care recipients could be receiving care from 'other relatives' and or 'family/friend' caregivers. People with spousal caregivers received an average of 60.12 hours per week, those with child-or-child in law received 57.47 hours and lastly, those with a friend or neighbour caregiver received 52.11 hours per week.

Table 9: Nova Scotia Caregiver Benefit Clients from Program Launch to Dec. 1, 2013: Relationship Between Caregiver and Care Receiver by Hours of Care, by Marital Status & Caregiving Relationship

Relationship Between Caregiver & Care Recipient	Overall percentage of caregiving relationships	Average hours of Care per week
Child/Child In Law	41%	57.47 hours per week
Spouse	32.9%	60.12 hours per week
Other Relative	23.6%	68.20 hours per week
Friend/Neighbour	2.5%	52.11 hours per week

Source: Government of Nova Scotia, 2013.

Policy Analysis: Manitoba

Equity. In terms of income, the Manitoba Primary Caregiver Tax Credit is offered impartially, as it does not take a person's income into consideration or provide a

[2] 141 clients were reported to have received less than 20 hours of care per week.

more substantial benefit to certain socioeconomic classes. The nature of this tax credit is fully refundable, meaning that any caregiver, regardless of income, can receive it if he/she and the care recipient meet the eligibility criteria. The province of Manitoba does not record other information such as the sex or age of the care recipient because they are simply not relevant to the credit as "eligibility is defined by assessed care need and residency within a regional health authority" (Roxie Eyre, personal communication 2013).

The Manitoba Primary Caregiver Tax Credit appears to be universally available to those living and providing care in Manitoba. There are however, guidelines and eligibility criteria that must be met in order for a person to be eligible to receive the tax credit. Whether or not a caregiving relationship is able to receive the Primary Caregiver Tax Credit is fundamentally based on the care recipient, not the caregiver. Despite this, the eligibility criteria appear to be fairly inclusive and allow a diverse group of people to receive the Manitoba Primary Caregiver Tax Credit. For example, important to the equity analysis of this tax credit is the fact that a person is not required to live with the care receiver or be related to them. Extending the tax credit to people beyond family, means that friends and neighbors may be willing to provide care, and they will be able to receive financial assistance through the Primary Caregiver Tax Credit.

It should be noted that through key informant interviews, it was revealed that the Manitoba Primary Caregiver Tax Credit is available only to those living within a Regional Health Authority. This means that people caring for a person living on a First Nations Reserve are not eligible for the Primary Caregiver Tax Credit. This is due to the fact that issues related to First Nations people fall under Federal jurisdiction (Privy

Council Office, 2013). Aboriginal Affairs and Northern Development Canada does however, offer a variety of supports and programs that may benefit the caregivers of people living on First Nation Reserves.[3]

The Primary Caregiver Tax Credit falls under the umbrella of the Manitoba Home Care Program. In order to be eligible to receive the credit, the care receiver must be assessed at a level 2 or higher under its program guidelines. Non-home care recipients may also receive the tax credit following a comprehensive assessment that follows the guidelines of the Home Care Program. If a person does not meet at least a level 2 assessment level, their caregiver would not be eligible to receive the tax credit, despite the amount of time they put into providing care.

Adequacy. Fully compensating for the lost wages of family/friend caregivers in Manitoba was not the government's intention when they created and implemented the Primary Caregiver Tax Credit. Key informant interviews revealed that the Primary Caregiver Tax Credit was implemented as a way to recognize the work of family/friend caregivers. The Manitoba "Seniors and Healthy Aging Secretariat, with Dr. Laura Funk (University of Manitoba), obtained the input and guidance of caregivers in Manitoba,

[3] Some programs provided by Aboriginal Affairs and Northern Development Canada include, The Income Assistance Program, The Assisted Living Program "Eligible Expenditures is financial assistance provided to people who require "non-medical personal care services" (Aboriginal Affairs and Northern Development Canada, 2012). These programs, which are provided through the Federal Government, could act in a similar manner to the Primary Caregiver Tax Credit, which is meant to support caregivers in the role of providing care to a person in the home.

through surveys and focus groups" (Funk, 2012). This was done during the caregiver consultation of 2012, which saw 400 caregivers come together to share information on their experiences. According to SPE, Shannon Kohler (2013), the consultation revealed that many caregivers involved felt recognized and valued by receiving the Caregiver Tax Credit. Knowing their work is valued, and receiving something as a means of recognition, could help to maintain the care giving relationship.

PE, Roxie Eyre (2013), stated the current benefit is a "rich type of tax credit" as a person can receive the $1,275 for up to 3 people per year. "Increasing the volume of recipients could prove to be financially difficult for the province" (personal communication). This is where a cost benefit analysis could be conducted in Manitoba, in order to determine if it does save the province money by keeping people out of long-term care for longer periods of time. If it is determined that the Caregiver Tax credit does help keep people out of long-term care facilities, it may be a good financial plan for the province to increase the credit.

The Manitoba government also implemented the Caregiver Recognition Act as a means to further recognize the work of family/friend caregivers. The Caregiver Recognition Act was implemented in 2011, to "establish a legislative framework to increase awareness and recognition of Manitoba's informal or family caregivers, and acknowledge their valuable contribution to society" (Government of Manitoba, 2011). According to SPE Shannon Kohler (2013), having this Act has helped to initiate discussions regarding how to improve the lives of caregivers. This is done largely through interdepartmental working groups who work together on different issues pertaining to the lives of family/friend caregivers.

As a means to further improve the tax credit, dual policy expert Bonnie Schroeder (2013), stated the support should be part of a greater package meant to help caregivers support their own health needs, while giving them access to respite through community and employer involvement. Similarly, PE Roxie Eyre (2013), stated that Manitoba's support could be improved if society "moved toward a 'culture of caring' by increasing access to respite care so that people can remain in the community longer (personal communication, 2013). TE Michael Rennie (2013), of Manitoba, stated that the Primary Caregiver Tax Credit is a positive part of the government's budget as it "defrays some of the out of pocket expenses and can cover some of the costs of respite" (personal communication).

Suitability/appropriateness. The questions asked under the umbrella of suitability/appropriateness are difficult to fully address. It must first be considered that Manitoba offers a fully refundable tax credit to all eligible caregivers whether or not they are paying income tax. According to taxation expert Michael Rennie, Senior Taxation Analyst, Fiscal Research Division, in order to create a policy that addressed the current needs of caregivers and care recipients; research for the policy was based on a survey of literature that highlighted the needs and demographics of Canadian family/friend caregivers (personal communication, 2013). Once the government decided to implement the policy, consultations were made with the Senior's and Healthy Aging Secretariat (Shannon Kohler, personal communication, 2013). Here SPE Shannon Kohler, along with her colleagues, "were consulted in the roll out of the program and worked across departments to ensure senior issues were reflected in the policy" (personal

communication, 2013). After the implementation of the policy, the needs of caregivers continued to be considered.

Given that the Tax Credit was implemented in 2009, there are still things that can be improved upon to mitigate the needs of the client. For example, SPE, Shannon Kohler (2013) stated that educating health professionals and other organizations who interact with caregivers could help improve the overall lives of the caregiver. Having health professionals, who are knowledgeable about services available to caregivers, could decrease health related issues that can often accompany a caregiving relationship.

Academic expert, Dr. Kerstin Rogers, Assistant Professor in the Department of Family Social Science at the University of Manitoba (2013), indicated that Manitoba has tried projects and policies that were respite care oriented but were ultimately met with various roadblocks and were unsuccessful. Creating a provincial or federal respite strategy could help to decrease caregiver burnout and prolong the caregiving relationship. This could be accomplished in partnership with the already existing tax credit, to further improve the lives of the province's older adults and caregivers. Additionally, policy expert Roxie Eyre, Consultant Continuing Care Branch (2013), stated that increasing respite could help keep a care receiver in the community longer and that the province is working on a number of projects to address this issue.

Although the tax credit is meant to act simply as a form of recognition, many family/friend caregivers may come to depend on the $1,275 (for up to 3 care recipients) each year. Many family/friend caregivers may have to reduce their paid hours of employment or relinquish them altogether, as the care needs of the care recipient increase. This means a loss of income for the family/friend caregiver and anyone else

they support financially, including a spouse and/or children. $1,275 annually works out to be just over $24.50 a week. However, fully compensating for lost wages is simply impossible. The amount allocated to the tax credit is meant to go towards things that will enhance the lives of the care recipient and potentially make the lives of caregivers more comfortable. An example of this would be allocating the funds from the tax credit to respite care, so that the caregiver can have a break from their caregiving duties. It is also important to note that the Primary Caregiver Tax Credit is an annual lump sum payment. This means that the caregiver must be careful to budget this money in a way that best suits their particular caregiving relationship.

This support does not meet the full needs of the caregiver because many may still experience financial hardships during their time as a family/friend caregiver, especially in considering that this is a delayed system of support. However, it should be noted and as previously mentioned, this was not the intent of implementing this form of support. The Primary Caregiver Tax Credit compliments already existing forms of support such as the home care program, and is meant to be a form of recognizing the work they do and cutting costs for out of pocket expenditures. In a survey of Manitoba family/friend caregivers, it was found that the caregivers "felt that this financial impact was being recognized by the government through the Manitoba Primary Caregiver Tax Credit" (Government of Manitoba, 2013).

All key informant interviewees agreed that the Primary Caregiver Tax Credit should remain part of the Manitoba provincial budget. It was agreed, that although some aspects of the support can be improved (such as outreach and education); it is an overall successful and positive component of the yearly provincial budget. As of October 15,

2013, there were 1,068 tax credit applicants who were home care clients and 1,483 non-homecare clients, for a total of 2,551 new applicants in 2013. These numbers represent the number of applications, not ongoing credit recipients (Roxie Eyre, personal communication, 2013). Between 2009 (tax year) and as of October 15, 2013, there have been 11,215 Primary Caregiver Tax Credit applicants. Although no data exists that determines whether or not a person would be more likely to enter long-term care if their caregiver was not receiving the tax credit, there are a large group of people who are being recognized for their contributions to society through providing care. This support, through recognition, may help a caregiver to sustain the caregiving relationship. Prior to 2009, this financial assistance and recognition did not exist, giving no formal recognition to family/friend caregivers.

Sustainability. The Primary Caregiver Tax Credit is identified as an addition to the Home Care Program and means of extra financial assistance to those who are not part of the program. It is difficult to say whether or not a person would have to enter long term care earlier if the support was not available. Dollar value alone, this support is not enough to keep a person from entering long term care sooner. However, in considering that this support is meant to be a form of recognition and support for family/friend caregivers, the tax credit may be enough to give the caregivers the willingness to continue on with their role. Manitoba has provided complementary supports and initiatives in an attempt to improve the lives of family/friend caregivers. This includes implementing the Primary Caregiver Tax Credit, increasing the dollar value of this, and implementing the Caregiver Recognition Act and educating caregivers on supports available to them. These complementary supports/forms of recognition may be what give

family/friend caregivers the drive and ability to continue in their caregiving role. With this, it is important to note that when receiving the Primary Caregiver Tax Credit, the supports received through the homecare program are in no way diminished or eliminated, which makes the programs complementary. There are also a number of other government and community supports available locally, provincially, and federally that may be used with the Tax Credit to further strengthen the caregiving relationship. These may include federal tax credits, resources from the Alzheimer's society, support groups, respite care etc.

Family/friend caregivers often experience financial, emotional and physical strain that can lead to injury and burnout, forcing their care recipient to enter long-term care, prematurely. Knowing they are recognized and supported and having knowledge of the supports available in their community may help caregivers to maintain balance in their lives and therefore help them to continue their commitment to a caregiving relationship.

Policy Analysis: Nova Scotia

Equity. Similar to that of Manitoba, the Nova Scotia government also implemented a support in 2009, meant to assist family/friend caregivers during the caregiving relationship. In terms of equity, the Nova Scotia Caregiver Benefit does exclude people who could be potential applicants, based on their age. According to Nova Scotia Health and Wellness (2013), the caregiver is required to be a resident of Nova Scotia who is 19 years of age or older. Additionally, the care receiver must be at least 19 years of age or older, in order for their caregiver to be eligible to receive the benefit. This has the potential to leave out a group of caregivers caring for disabled persons under the

age of 19, unlike Manitoba, which allows the care receiver to be under 19. The key informant interview with policy expert Susan Stevens (2013), from the Nova Scotia Department of Health and Wellness revealed, "parents of severely disabled children have indicated that they want to access the benefit, but at this time they do not qualify" (personal communication, 2013). Similar to the caregivers of older adults, the caregivers of severely disabled children may have to reduce some hours of paid employment in order to care properly for their child. This may cause a financial strain on the caregiver and the rest of their family. PE Susan Stevens (2013), stated the benefit could be improved if it reached more caregivers, like those of severely disabled children. There are however, financial barriers to expanding a support in order to reach new people. According to PE Stevens (2013);

> "The dollar value allocated to the Caregiver Benefit is over 5 million dollars annually and is supporting around 1200 caregivers. Anytime you want to expand a service, you have to have more money. If we changed the criteria, we could reach more people. These additional people could be the parents of disabled children or people with a lower level of need than what is currently recognized as a requirement to receive the benefit" (Susan Stevens, personal communication, 2013).

As mentioned, this would require an increase to the Caregiver Benefit budget, which may not be economically feasible at this time.

The Caregiver Benefit is targeted toward lower income individuals. The income of the care recipient is what is used to determine whether or not a caregiving relationship meets the eligibility requirements to receive the Caregiver Benefit. According to Nova

Scotia Health and Wellness (2013), the care receiver must "have a net annual income of $22,003 or less if single, or a total net household income of $37,004 or less". Anyone who is caring for an individual with a higher income is ineligible to receive the benefit. The assumption is that the higher income care recipients would be more likely to be in a position to compensate the caregiver for their assistance. Having an income requirement that reflects the income of the caregiver instead of the care receiver could possibly lead to an increase in the number of caregivers, an increase in uptake and prolonged caregiving relationships, as more caregivers would be supported, regardless of the income of the care receiver.

Also in terms of equity, the Nova Scotia Caregiver Benefit is a very positive support in that it does not exclude spousal or child caregivers. This extends beyond the notion that it is the responsibility of the family to provide care, and recognizes that they too may experience financial difficulties while providing care. Additionally, such caregivers are not required to live with the care recipient; this arguably allows the caregiver to maintain some autonomy from the caregiving relationship.

Adequacy. Although the Caregiver Benefit certainly contributes financially to a caregiving relationship, considering the amount allocated to the benefit, it certainly does not replace lost wages or amount to a monthly wage that could be earned outside the home. According to PE Susan Stevens (2013), the Caregiver Benefit was not intended to be a wage replacement, as this would be a different program all together. The Caregiver Benefit is meant to "recognize that a caregiver is in a caregiving relationship" (Susan Stevens, personal communication, 2013). A caregiver may use the money however they wish, but it is intended to go toward supporting the caregiving relationship. The

Caregiver Benefit was implemented with the idea that it would "help to sustain the caregiving relationship as it was recognized, that being a caregiver may require additional finances" (Susan Stevens, personal communication, 2013). The amount allocated to the benefit is also considered positive by caregiver advocates at Caregivers Nova Scotia. Campbell (2013) stated the benefit "could be used to pay bills, make ends meet or for respite care…the benefit may not be a lot of money but it could be enough to keep things afloat" (Angus Campbell, personal communication, 2013). Caregiver advocate Campbell (2013) also stated that the support could always go further to better support caregivers, but is currently a good form of recognition.

As a way to improve the Caregiver Benefit, Caregiver Advocate Angus Campbell of Caregivers Nova Scotia, suggested a sliding scale for income qualifications, similar to those used in nursing homes. Similarly, government representative/ health critic, MLA Chuck Porter, believes that the best way to improve the benefit is to "put people first and stop thinking about the money" (personal communication, 2013). Mr. Porter also stated that the income of the care recipient should not be the deciding factor and that the income threshold should be reevaluated. This of course could be very costly for the province, but it has already been found that care recipients whose caregivers are receiving the benefit, are less likely to enter long-term care (Warner, MacDougall and Poss, 2013). Therefore, increasing access to the benefit may save the province more money in the long run.

Suitability/appropriateness. In creating the Caregiver Benefit, the needs of the caregiver were taken into account. Through the key informant interview with expert caregiver representative Angus Campbell, Executive Director for Caregivers Nova Scotia, it was revealed that Caregivers Nova Scotia advocated for the caregiver benefit by

working closely with the Nova Scotia Department of Health and Wellness, their funder (Angus Campbell, personal communication, 2013). This was done by raising caregiving concerns to the Department of Health and Wellness (Angus Campbell, personal communication, 2013). In order to ensure that the changing needs of caregivers are being met, the Department of Health and Wellness is in regular contact with Caregivers Nova Scotia (Angus Campbell, personal communication, 2013).

In an effort to meet the needs of the clients, ECR, Angus Campbell (2013), stated that one of the areas that has the most room for improvement is outreach, and the use of technology. "Younger generations of caregivers will demand to be connected to the internet. Right now there are limitations surrounding technology because current caregivers may not always be using the internet" (Angus Campbell, personal communication, 2013). This is a sentiment that is shared by Leo Glavine, Minister of Health and Wellness, who shared that having seminars and meetings where caregivers could share their experiences and knowledge could help to improve their day-to-day lives. "Finding ways to get valuable information into the hands of caregivers is really important and should be expanded…we need to find those mechanisms to support caregivers" (Honorable Leo Glavine, personal communication, 2013). Current caregivers may benefit more from verbal communication from health professionals with whom they come in regular contact. This would require further educating these professionals about the province's support so that they may then share the information with caregivers. This is a sentiment that was shared by the Manitoba Key Informants.

Another component of educating caregivers is providing information on available respite care. According to ECR Angus Campbell (2013) many Nova Scotia caregivers are

not aware that they are ‘entitled’ to respite care. Having respite care would eliminate some of the hardships and provide a much needed break to those providing long-term care in the home. This type of care often comes at a cost to the caregiver, and will be discussed further below.

In order to be eligible for the Benefit, the care recipient must “have a care assessment completed by a Continuing Care Coordinator, indicating a very high level of impairment or disability, requiring significant care over time” (Government of Nova Scotia, 2013). The caregivers of those who are deemed eligible would receive $400 per month, in an effort to help offset costs associated with providing care. By receiving the Caregiver Benefit, it is believed that the caregiver will feel more supported and recognized, which will help to reduce the chances of caregiver burnout. Having a caregiver who feels supported could help the care recipient receive the care they need and thus prolong the caregiving relationship. In addition to the Caregiver Benefit, a care recipient may be eligible to receive Home Care Services, which “supplement the help people already receive from their family, friends or community” (Government of Nova Scotia, 2014d). Supports that fall under Nova Scotia’s Home Care Services can include respite care, which can directly benefit the caregiver (Government of Nova Scotia, 2014d).

Government representatives report positive feedback about the Caregiver Benefit. Such information is more qualitative or anecdotal, according to Policy Expert Carolyn Maxwell, Director, Liaison and Service Support, Continuing Care Branch of the Department of Health and Wellness. This information has come from conversations with directors at Continuing Care and the District Health Authorities (Carolyn Maxwell,

personal communication, 2013). These directors are responsible for managing the Care Coordinators that go into the homes of care recipients. Through her conversations with the directors, Maxwell has been informed that the benefit "has been exceptionally positive with really good feedback from people who have been approved to receive it. It has also been well received by the Caregivers Nova Scotia and other groups that provide support for caregivers" (Carolyn Maxwell, personal communication, 2013). This positive feedback suggests that the needs of some caregivers and care recipients are being met. Although the income test of the Caregiver Benefit has the potential to exclude a number of caregivers, it should be noted that because it is income tested, the benefit is considered social assistance and is not taxed by the government (Susan Stevens, personal communication, 2014). This is a very positive factor, as the caregiver maintains all of the monthly payment. First, the income is based on the care receiver so the income of the caregiver is not affected. Second, the Benefit is paid directly to the caregiver, so that they may decide how they wish to use the money (Nova Scotia Department of Health and Wellness, 2013).

Sustainability. Similar to the tax credit in Manitoba, the Nova Scotia Caregiver Benefit is meant to be a means of recognizing the hard work and added expenses of family/friend caregivers. Receiving $400 per month as a means of recognition, may help to sustain a caregiving relationship as the caregiver will feel more supported, which as previously mentioned, helps reduce challenges related to caregiving. When put toward enhancing the caregiving experience, the Caregiver Benefit could go toward respite care, travel expenses, adapting the home, etc. People not receiving this support may not feel as supported as those who are and may run into difficulties with their finances and mental

and physical wellbeing. This lack of support could lead to a premature end to the caregiving relationship. A recent study by Warner, MacDougall and Poss (2013), which took into account various assessments, current clients and potential clients for the caregiver benefit, found that "clients who receive the caregiver benefit are 56% less likely to be admitted to long term care". If the benefit reached all eligible caregivers (N=9298 for this particular analysis), it found that there could potentially be 1,300 less admissions to long term care per year (Warner et al., 2013). This is a significant number, when considering the cost of long-term care or ALC hospital stays when long-term care beds are unavailable. However, there are other government services (such as Home Care) available that may further assist those receiving the Caregiver Benefit to stay in their home.

By analyzing the inactive client cases of the Nova Scotia Caregiver Benefit, it is possible to calculate the approximate cost of the benefit. In total, 1,336 inactive cases (cases where a person has started and stopped receiving the benefit) spent 14,574 months as Caregiver Benefit clients. Taking into account that clients receive $400 per month, this amounts to a total output by the government of $5,829,600. On average, caregivers receive the benefit for 10.92 months resulting in the average cost per case of $4,368, without taking into account additional costs for assessments and administration.

In addition to receiving the Caregiver Benefit to assist the caregiving relationship, a care receiver may also receive Home Care through the province. Home Care is a service provided through the province's Department of Health and Wellness and is meant to compliment/supplement the care a person already receives in the home from their family (Government of Nova Scotia, 2014c). Services provided through Home Care can include

Home Support, which assist the client with activities of daily living, and nursing which involves more of the medical aspects of caring for someone in the home (Government of Nova Scotia, 2014). In order to understand a more holistic cost to government of having someone remain at home, these home care costs need to be calculated and added to the cost of the caregiver benefit.

Through dialogue with key informants, an estimate of the average hours of home care for clients who met the care requirement of assessing the Caregiver Benefit (e.g. MAPLE score of at least 4 with additional conditions) was about 100 of home support hours per month. According to the Nova Scotia Department of Health and Wellness, the average monthly cost of each case for these services (100 home support hours per month) is $4,751 or an average cost per case of $51,881 for 10.92 months. The average monthly cost of both Caregiver Benefit and home care costs is $5151, resulting in the overall cost combined, the average case receiving Home Care and the Caregiver Benefit costs the government approximately $56,285.

When acknowledging only Caregiver Benefit clients who have not/did not enter long term care, the potential savings of the government becomes further apparent. Of the original sample provided (N=2854), 2228 had not (yet) entered a long term care facility, 1485 cases were still active as of 2013, but 743 cases were inactive (See Figure 5). Almost 500 (n=499) cases were deemed inactive because of the death of the client meaning that these clients died before entering long term care facility.

The cost to government of a long term care placement is significant. The average per diem cost of a long-term care facility is $248.59 (Department of Health and Wellness, personal communication, 2014). The government covers $146.09 of the per diem on a

daily basis, if the client pays the entire accommodation cost. Many Nova Scotia long-term care residents may not be able to cover the entire accommodation cost. For this reason, a resident can apply to have their rate reduced, "by undergoing an income-based assessment" (Government of Nova Scotia, 2014c). As reported above, almost 500 people never entered long-term care, thus the savings of the Caregiver Benefit to government becomes more profound. In these cases the government whether neither have incurred the health costs of long term care nor the portion of the accommodation costs that are not covered by some residents.[4]

For this particular analysis, it will be assumed that most Nova Scotia long-term care residents do not pay the full accommodation fee of $102.50. A scenario is proposed whereby residents pay half of accommodation costs or $51.25 per day. This scenario results in public funding being an average of 197.34 per day (out of the total 248.59) for low to mid income long-term care residents. This equates to approximately $6,002 per month or $65,546 for 10.92 months. This highlights the high costs of long-term care in

[4] Without taking the health costs of staying in a long term care facility into account, the cost of the benefit can be compared to the accommodation costs of long-term care, which are covered by individual residents. As previously mentioned, a person receives the Caregiver Benefit for an average of 10.92 months. If a person were in a long-term care facility for 10.92 months and were capable of paying the entire accommodation charge of $102.50 a day, the charge would total $3,117 per month or $34,045 for 10.92 months. This was arrived at by multiplying the daily cost, $102.50 by the average number of days in a month, 30.4167 and then multiplying by the average number of months (10.92) a person receives the benefit.

Nova Scotia, especially in considering the aging population and predictions, that soon there will be more people requiring assistance than ever before.

Table 10: Approximate Cost of Long-Term Care Costs for Resident & Government

	Cost for Residents			Cost for Government	
	Average cost per month (30.4167 days) for resident	**Average Cost for 10.92 months for resident**	**Per diem cost/ health cost covered by government ($248.59 accommodation fee)**	**Average cost per month (30.4167 days) for government**	**Average cost for 10.92 months for government**
Full Accommodation fee payment ($102.50)	$3,117	$34,045	$128.09 per day	$3,896	$42,544
Partial Accommodation fee payment (low income residents) ($51.25)	$1,558	$17,022	$197.34 per day	$6,002	$65,546

Table 11 compares the estimated cost to the government of having the case remain in the community with the cost of entering in a long term care facility for the average amount of time that the cases received the Caregiver Benefit (10.92 months). Usually the data from the inactive cases of Caregiver Benefit (N=1336- See Figure 4), the estimated cost to the government had that those 1336 clients entered a long term care facility for the average 10.92 month is $87,570,165. The cost of keeping them in the community with the Caregiver Benefit and Home care services is $75,168, 664. This equates to a difference of $12,421,501. This provides preliminary evidence of the sustainability of the Caregiver Benefit, especially in considering a new study found that people who receive the benefit are less likely to enter long-term care (Warner et al., 2013). This would result in a reduction of government expenditures in long-term care

(Warner et al., 2013). Although the Caregiver Benefit is a very positive component of the Nova Scotia provincial government, as it, along with other services such as Home Care, help people remain in the home, there are additional services that also help people remain in the community including, respite services, caregiver and dementia support groups and resources from Caregivers Nova Scotia and the Alzheimer's Society, Federal initiatives etc. A truly sustainable and successful caregiving relationship is arguably one that takes full advantage of all available resources and forms of assistance.

Table 11: Cost of Caregiver Benefit Compared to Cost of Long-term Care

	Monthly Cost	**Cost Per Individual for 10.92 Months**	**Total Cost for 1336 People (10.92 months)**	**Approximate government output for 10.92 months**	**Approximate Difference**
Caregiver Benefit	$400	$4,368	5,835,648	$75,148,664	**$12,421,500.80**
Approximate cost of Home Care (100 hours)	$4,751	$51,881	$69,313,016		
Approximate Cost of Long-term Care	$6,002	$65,546	$87,570,164	$87,570,164	

Chapter 6: Discussion

This research consisted of an in-depth case study analysis and comparison of two Canadian provinces that offer new and unique means of supporting family/friend caregivers through either a benefit or a tax credit. To frame this analysis, two research questions were developed:

1: "What were the driving forces behind the implementation of the Manitoba Primary Caregiver Tax Credit and the Nova Scotia Caregiver Benefit and what are the benefits and limitations to having such a support?" and;

2: "What are the shared characteristics among the family/friend caregivers who are accessing these supports?"

Applicability of the Model

Initially the Andersen Newman Model was proposed to guide this analysis. This, however, proved to be difficult to fulfill to the fullest extent because the provinces did not collect many of the variables in the model. Nevertheless, some portions of the Andersen Newman Model proved to be beneficial when considering the different eligibility criteria of the two family/friend caregiver policies. When considering the eligibility criteria and preexisting factors related to the individual, along with considering predisposing, enabling, and need factors, we gain a better understanding of who can receive the two supports. For example, "some individuals have characteristics that exist prior to the onset of a specific episode of illness", such as age (predisposing factors) (Andersen & Newman, 1973, p. 108), that determine eligibility for the Nova Scotia Caregiver Benefit. Enabling factors, such as family resources, including income, specifically relates to the

eligibility criteria in Nova Scotia, because there is a maximum income a care recipient can receive in order to be an eligible client. This could potentially leave out a number of caregiving relationships, if the income of the care recipient is too high. Lastly, need factors may relate to the eligibility criteria in both provinces, which indicate that the care recipient must require a certain level of care and assistance, a factor that is higher in Nova Scotia than Manitoba, in order to receive the benefit. Although the Andersen Newman Model was not used as it was originally intended, it was a useful tool in understanding the differences in eligibility criteria between the two provinces, and also how the differences in these criteria could identify the caregivers/care recipients, or exclude them from receiving the support.

Applicability of Methodology

Case study was chosen as the method used to carry out this analysis. Under the umbrella of the case study analysis were multiple methods of inquiry, including key informant interviews, policy document analysis and evaluations, and secondary data (administrative) analyses. The findings of these methods were synthesized to gain a comprehensive understanding of utility of policies supporting caregiver in both Manitoba and Nova Scotia.

Both case studies conclude that both caregiver policy instruments are perceived as very positive components of the province's care strategy. However, one area where improvement is needed is public outreach and increased public awareness. For example, key informants in both provinces revealed that connecting with the public and potential applicants/clients could be improved.

The province of Nova Scotia was able to provide extensive data that demonstrated who is currently accessing the Caregiver Benefit. This allowed for a more robust and definitive case study analysis than in Manitoba, where many of the original variables of interest are not collected. Various results and outcomes of the case study analysis will be discussed in the following sections.

Caregiver Policy: Manitoba Compared to Nova Scotia

By analyzing the uptake of the supports in Manitoba and Nova Scotia's Health Authorities that contain the provinces' biggest cities, and comparing them to the other Health Authorities combined, the researcher was able to determine where most tax credit and benefit clients live. There are more people accessing the Primary Caregiver Tax Credit in Manitoba's WRHA, which contains the province's biggest city, Winnipeg, in comparison to all of the RHAs combined. This may be due to a denser population and an increased availability of community supports. For this reason, it may be beneficial for this province to reevaluate social supports and educational workshops for caregivers in other areas of the province. In contrast to this, it was determined that there are more people accessing the Caregiver Benefit of Nova Scotia in the smaller combined DHAs in comparison to the Capital Health DHA, that contains the province's largest city. This could be a reflection of the interesting dynamics of Nova Scotia that have seen younger people leaving rural areas in recent years to find work, leaving a greater population of older people who may be in need of assistance. Additionally, the Nova Scotia Caregiver Benefit is income tested. The fact that there are more people accessing this support in

more rural areas may be a reflection of a high number of low-income care recipients in this area.

Ten key informant interviews with policy experts and caregiver advocates from Manitoba and Nova Scotia were conducted in order to understand the driving forces around the implementation of the policies and in order to become familiar with the eligibility criteria and background documents of the supports. The most common theme that arose from these interviews, in both provinces, was that both supports are viewed as a positive policy addition to their provinces. The governments of both Manitoba and Nova Scotia recognized that they had growing groups of caregivers who needed some support during their time of providing care. Both policies implemented a support in 2009, which were meant to recognize the contribution family/friend caregivers make to society and were not meant as a wage replacement. In Nova Scotia, the benefits of the policy were attributed to anecdotal information from caregivers, received by key informants, as well as independent analysis that suggested positive economic benefits of the policy, such as a delay and/or reduction in usage of expensive institutional care (Warner et al., 2013). A similar cost benefit study was not found for the province of Manitoba.

The Manitoba Caregiver Consultation Final Report prepared by Dr. Laura Funk found that caregivers in Manitoba perceive the Primary Caregiver Tax Credit to be a positive component of their caregiving relationships. This was determined by conducting a consultation with 400 Manitoban caregivers. In addition to this, key informant interviewees in both provinces had heard directly from caregivers that the support was a positive addition to their caregiving experience.

Educating health professionals about the policies, in order to improve uptake, emerged as an important theme in this research. Today's caregivers and care recipients may not be as computer literate as future generations of caregivers. It is therefore very important that governments do not rely on the Internet as their primary means of communicating what is available for caregivers, as the people who need it most may not have the ability to access it. Health professionals, who have regular contact with caregivers and care recipients, need to be educated on caregiver support options in order to transfer this knowledge to caregivers themselves and assist them to utilize their provincial support. Another very common theme throughout the interviews was a need for improving access to respite care at both the provincial and federal level, so that a caregiver can receive some relief during their caregiving relationship.

As mentioned above, this analysis sought to determine whether these supports were implemented for economic reasons "to reduce or delay the institutionalization of the person with care needs and thereby decrease the cost of the health care system" (Keefe & Rajnovich, 2007, p. 83), or for social reasons, to recognize and support the contributions of caregivers while supporting the informal care system. By conducting key informant interviews, it became apparent that both these supports were implemented mainly for social reasons, as a means of recognizing and supporting the very important work of informal caregivers. Neither support is meant to replace wages or to be viewed as the equivalent of employment. Determining if the supports were also implemented for economic reasons becomes more difficult for Manitoba in particular, as cost benefit analyses that determine if the support helps a care recipient stay out of long-term care, have yet to be conducted.

A recent study in Nova Scotia found that care recipients in relationships that receive the Primary Caregiver Benefit, are far less likely to enter long term care than those who do not receive the benefit (Warner, et al., 2013). This is evidence that the Nova Scotia Caregiver Benefit has both economic and social benefits. This was also identified by determining the financial cost of long-term care in Nova Scotia, and comparing it to the cost of the Benefit.

Addressing the question of which support better provides for family/friend caregivers remains extremely difficult to identify after conducting these analyses. Both have very positive components that recognize and support family/friend caregivers. Both supports have recognizable benefits and areas that have room for improvement. For example, the Manitoba Primary Caregiver Tax Credit is extremely positive because a caregiver can access the support regardless of income, as it is a fully refundable tax credit. The support could be improved if the dollar value was increased, as it is a one time, annual payment of $1,275. Additionally, as a tax credit, this support only benefits the caregiver at one time during an entire taxation year. It is therefore left to the caregiver to budget this small amount of money, in a way that best supports the caregiving relationship.

Nova Scotia's Caregiver Benefit is recognized as being extremely positive in that it offers a direct payment, monthly to qualifying caregiving relationships. This means that a caregiver can budget an extra $400 per month ($4,800 annually) to assist with the caregiving relationship. One of the weaknesses of the Nova Scotia Caregiver Benefit is the fact that the Benefit is income tested. To be eligible, this benefit takes into account

the income of the care recipient. A large number of caregivers may not qualify to receive the benefit if the income of the care recipient is too high.

Both supports have proven to be important components of their province's annual budgets. Many other Canadian provinces have yet to implement similar supports, however, based on the findings of this research, other provinces would most likely find that these supports help caregivers to feel recognized and that they have the potential to help care recipients stay out of long term care facilities for longer periods of time. Given the scope and importance of support for caregivers/care receivers, the ideal support would be one that combines the characteristics of Manitoba that does not use an income threshold, and, the monthly allowance allocated to the Nova Scotia Caregiver benefit. In the coming years it is projected that more people will continue to enter caregiving relationships as our population ages. Therefore, supports are needed that both recognize caregiver's contributions and assists them to financially carryout the responsibilities associated with care. The analyses of the Primary Caregiver Tax Credit and the Caregiver Benefit have demonstrated that it may be in the best interest of Canadian provinces/territories to implement financial supports for caregivers. As waiting lists for long-term care facilities continue to grow, both from the community and from people waiting in hospitals, greater attention must be given to supporting care in the community through enhanced home care programs and supports for family/friend caregivers. This research has demonstrated that by providing financial support policies for family/friend caregivers, the social and economic benefits will be measured by the increased number of care receivers who are able to remain in their homes, and the money that governments

will save by enabling caregivers to maintain the caregiving relationship by keeping the care recipient out of long-term care facilities or hospitals.

Study Limitations

Several limitations of this study must be acknowledged. First, Manitoba does not have information on characteristics of family/friend caregivers who are accessing their caregiver support policy (Research question 2) as they are not needed to determine eligibility. It was the intention of the researcher to determine if characteristics such as sex of the caregiver and care recipient, for example, have remained consistent since the implementation of the two supports. Nova Scotia does record this information, however it was not separated specifically by year. Another important variable that was unavailable was the income of the caregiver, as neither province takes this into account. It was anticipated that in conducting this analysis, that future supports could target groups that are most likely to access the support. It may be beneficial for the provinces to record this information despite whether or not it is used for eligibility, so that it can determine if they should be targeting specific groups.

In regard to which of the four identified types of caregivers provide the most hours of care in Nova Scotia, a limitation was discovered in the data set. It was discovered that 141 Caregiver Benefit clients were reportedly receiving less than the 20 hour minimum of care per week, required for eligibility. This may have skewed the results of the ANOVA to some extent. However, reasons behind this limitation were not discovered.

Additional limitations came to light when conducting the key informant interviews with people in the province of Manitoba. The researcher was unable to successfully contact past or present politicians who were involved in the creation of the tax credit, or who were in office at this time. Additionally, the researcher was unable to successfully contact a key informant from a caregiver advocacy group in Manitoba. This did not prove to be a great limitation as there was valuable information uncovered through the other key informant interviews.

Future Research

Based on this research, a cost benefit analysis in Manitoba, similar to the one conducted by Warner et al., (2013), should be conducted to determine if the Primary Caregiver Tax Credit is enabling people to remain in the home longer than if they were not receiving the support. Completing such an analysis, based on the data gathered, could help determine if, and how much, the support has the potential to save the government.

Additional research in Nova Scotia and Manitoba should address the actual individual opinions of caregivers receiving the benefits in each province. This would help determine if the supports are perceived to be positive by the people who are actually using/benefiting from them. Gaining access to caregivers in each province could prove to be difficult, but may be the best way to improve the support.

As previously mentioned, it was found that more people access the caregiver support in Manitoba's RHA with the provinces largest city. In contrast to this, more people access the Caregiver Benefit outside of Nova Scotia's DHA that contains the province's largest city. Future research should look into the core reasons behind this, to

determine if it is because of a difference in demographics, such as age and income, the overall eligibility criteria of the supports, or the ability to spread awareness about the supports.

Conclusion

Provincial governments must give credence to the current practices of Manitoba and Nova Scotia by recognizing and perhaps considering the practices that have proven to work in these provinces. Given the need of senior care in a steadily aging society, governments may increasingly rely on the use of family/friend caregivers. Caregivers make it possible to keep care receivers out of hospitals and long-term care facilities, which not only benefit the care recipient but also saves the government tremendous amounts of money and makes Home Care possible.

Family/friend caregivers are an extremely important part of society in every Canadian province. As our population continues to age, and this Baby Boom generation requires care and assistance to remain in the home, society may increasingly rely on the use of family/friend caregivers.

Nova Scotia and Manitoba should both be commended for their efforts to recognize and support their family/friend caregivers. They have both done this by implementing very different supports with the same common goal, which is to support and recognize the caregivers they have come to rely on. Both of these supports have proven to be positive and important components of the Manitoba and Nova Scotia governments, and other Canadian provinces should wisely consider in implementing similar supports. The positive aspects of both of these supports far outweigh the areas

that require improvement. Other provinces that are considering the idea of implementing a support for family/friend caregivers could draw from both the Manitoba and Nova Scotia supports, as they have provided a good framework for other provinces to draw from. Key informant interviews made it clear that the driving forces behind implementing these supports was to recognize the contributions being made by family/friend caregivers so that they may feel more supported by their governments.

The approach used in this thesis was based on an analysis of two methods of supporting family/friend caregivers as practiced in Manitoba and Nova Scotia. Undoubtedly, more evaluation of these supports is needed, but at this point, the discussion must shift to the fundamental realization that as our population ages, we must have elements of support in place. Waiting will make it increasingly difficult to accommodate the changing needs of our aging population. We have already reached a critical point whereby action must be taken now, to mitigate the projected needs of our aging society. If we fail to do so we will have failed to assist the largest sector of our population, and will create, by our lack of action, a burden on all. Governments should take action similar to that of Manitoba and Nova Scotia.

References

Aboriginal Affairs and Northern Development Canada (2012). National Social Programs Manual. *Government of Canada*. Retrieved December 2013 from: http://www.aadnc-aandc.gc.ca/eng/1335464419148/1335464467186#chp1

Andersen R. (1995). Revisiting the behavioral model and access to medical care: Does it matter? *Journal of Health and Social Behavior, 36,1*. doi:10.2307/2137284

Baxter, P. & Jack, S. (2008). Qualitative case study methodology: Study design and implementation for novice researchers. *The Qualitative Report 13:4, 544-559.* Retrieved March 20 From: http://www.nova.edu/ssss/QR/QR13-4/baxter.pdf

Belluz, J. (2011). The end of hospitals. *Maclean's Magazine: Macleans.ca.* Retrieved December 2, 2012 From: http://www2.macleans.ca/2011/09/01/the-end-of-hospitals/

Bastawrous, Marina (2012). Caregiver burden- a critical discussion. *International Journal of Nursing Studies.* 50(2013) 431-441.

Canadian Institute for Health Information (2008). The cost of acute care hospital stays by medical condition in Canada, 2004-2005. *CIHI.* Retrieved March 10, 2013 from: https://secure.cihi.ca/free_products/nhex_acutecare07_e.pdf

CBC (2013). Canada's nursing homes: National statistics. *Canadian Broadcasting Corporation.* Retrieved February 20, 2013 from: http://www.cbc.ca/news/interactives/map-nursing-homes/

Policy. Retrieved March 10, 2013 from: http://mchpappserv.cpe.umanitoba.ca/deliverableslist.html

Fast, J.E., Williamson, D.L. and Keating N.C. (1999) Hidden costs of informal elder care. *Journal of Family and Economic Issues, 20(3), 301-326.*

Funk, Laura (2012). Manitoba caregiver consultation final report. *Prepared for the Seniors and Healthy Aging Secretariat, Ministry of Healthy Living, Seniors and Consumer Affairs.* Retrieved Feb 10, 2013 from: <http://www.gov.mb.ca/shas/caregiver_report.pdf>

Government of Canada (2012) Canada Health Act. *Health Canada.* Retrieved March 5, 2013 from http://www.hc-sc.gc.ca/hcs-sss/medi-assur/cha-lcs/index-eng.php

Government of Manitoba (2011). Caregiver recognition act would recognize caregivers' contribution to families, communities: Rondeau. *Government of Manitoba News Release.* Retrieved October 2011 from: http://news.gov.mb.ca/news/?item=11580

Government of Manitoba (2011). Primary Caregiver Tax Credit. *Manitoba Finance Tax Assistance Office.* Retrieved Sept 29, 2011 from: http://www.gov.mb.ca/finance/tao/caregiver.html

Government of Manitoba. (2013).Caregiver Recognition Act report 2013-14. *Healthy Living, Seniors and Consumer Affairs.* Retrieved February 2014 from http://www.gov.mb.ca/shas/caregiver_recognition_act_report_2013.pdf

Government of Nova Scotia (2009). Seniors statistical profile 2009. *Nova Scotia Department of Seniors.* Retrieved April 2014 from: http://www.novascotia.ca/seniors/pub/2009_StatProfile.pdf

Government of Nova Scotia (2011). Long term care beds. *Continuing Care Strategy.* Retrieved March 13, 2013. from:

https://novascotia.ca/seniors/pub/2009_StatProfile.pdfhttp://www.gov.ns.ca/health/ccs_strategy/ltc_beds.asp

Government of Nova Scotia (2012). Resident charge policy. *Health and Wellness.* Retrieved March 13, 2013 from: http://www.gov.ns.ca/health/ccs/ltc/policyManual/Resident_Charge_Policy.pdf

Government of Nova Scotia (2013). Caregiver Benefit. *Health and Wellness.* Retrieved February 27, 2012 from: http://novascotia.ca/dhw/ccs/caregiver-benefit.asp

Government of Nova Scotia (2013) District Health Authorities. *Nova Scotia Health and Wellness.* Retrieved Feb 2014 from*: http://novascotia.ca/dhw/about/dha.asp*

Government of Nova Scotia (2013) SEAscape database, Continuing Care Branch, Department of Health and Wellness.

Government of Nova Scotia (2014a). Browse data by geography. *Nova Scotia Community Counts.* Retrieved February 2014 from: http://www.novascotia.ca/finance/communitycounts/dataview.asp?gnum=pro9012&gnum2=pro9012&gname=&gview=3&glevel=pro&gtype=&ptype=&gsel=&table=table_d17&acctype=0

Government of Nova Scotia (2014b). Paying for long term care. *Nova Scotia Continuing Care.* Retrieved January 2014 from: http://novascotia.ca/dhw/ccs/FactSheets/Paying-for-Long-Term-Care.pdf

Government of Nova Scotia (2014c) Continuing care, long term care. *Nova Scotia Department of Health and Wellness.* Retrieved March 2013 from: http://novascotia.ca/dhw/ccs/long-term-care.asp

Government of Nova Scotia (2014d) Continuing care, home care. *Nova Scotia Department of Health and Wellness*. Retrieved January 2014 from: http://novascotia.ca/dhw/ccs/home-care.asp

Grant, K. Amaratunga, C. Armstrong, P. Boscoe, M. Pederson, A. & Wilson, K. (2004). Caring for/caring about: Women Home Care, and Unpaid Caregiving. Ontario: Garamond Press Ltd.

Hawkins, G. (2005). *Patterns and predictors of human care utilization in Eastern Canada: Analyzing changes over a 5-year period (1996-2001).* (Unpublished Master of Arts Thesis). MSVU Department of Family Studies of Gerontology, Halifax, Nova Scotia.

Health Canada (2011) Respite for family caregivers- an environmental scan of publically-funded programs in Canada. *Government of Canada*. Retrieved January 2014 from: http://www.hc-sc.gc.ca/hcs-sss/pubs/home-domicile/2003-respite-releve/index-eng.php#a3_4

Hollander, Liu, Chappell (2009). Who cares and how much? The imputed economic contribution to the Canadian healthcare system of middle-aged and older unpaid caregivers providing care to the elderly. *Healthcare Quarterly. 12(2) 42-49.*

Kang, Y. (2007). *Predictors of Help-seeking Among Community-dwelling Korean American Women with Urinary Incontinence*. (Unpublished doctoral dissertation). Faculty of the College of Nursing University of Arizona, Arizona. Retrieved January 2013 from: http://www.nursing.arizona.edu/Library/Kang_Youngmi.pdf

Keefe, J., Ogilvie, R., Stevens, S., MacPherson, D., & Stoddart, N. (2014) Provincial/Regional Variation in Availability, Cost of Delivery and Wait Times

for Accessing Home Care Services to Address Avoidable Admissions to Long Term Care, Alternate Level of Care Bed Days and Hospitalization. *Health Canada*, April 30, 2014.

Keefe, J. (2011). Supporting caregivers and caregiving in an aging Canada. *IRPP Study.* No. 23, November 2011. http://www.irpp.org/pubs/IRPPstudy/IRPP_Study_no23.pdf

Keefe, J. & Fancy, P. (1999). Compensating family caregivers: An analysis of tax initiatives and pension schemes. *Health Law Journal, Vol. 7, 1999.*

Keefe, Fancey, & White (2005). Consultation on financial compensation initiatives for family caregivers of dependent adults: Final report March 2005. *Mount Saint Vincent University Maritime Data Centre for Aging Research and Policy Analysis*

Keefe, J., & Rajnovich, B., (2007). To pay or not to pay: Examining underlying principles in the debate on financial support for family caregivers. *Canadian Journal on Aging, 26(S1), S77-90.* doi: 10.3138/cja.26.suppl1.77

MacCourt, P. & Krawczyk, M (2012). *Supporting the Caregivers of seniors Through Policy: The Caregiver Policy Lens*. Vancouver, British Columbia: Psychogeriatric Association.

Manitoba Health and Healthy Living (2009). Population report June 1, 2009. *Government of Manitoba.* Retrieved October 2013 From: http://www.gov.mb.ca/health/population/2009/pr2009.pdf

Manitoba Health (2010). Population report June 1, 2010. *Government of Manitoba.* Retrieved October 2013 From: http://www.gov.mb.ca/health/population/2010/pr2010.pdf

Manitoba Health (2011). Population report June 1, 2011. *Government of Manitoba.* Retrieved October 2013 from: http://www.gov.mb.ca/health/population/2011/pr2011.pdf

Manitoba Health (2012). Population report June 1, 2012. *Government of Manitoba.* Retrieved October 2013 from: http://www.gov.mb.ca/health/population/pr2012.pdf

Manitoba Health (2013). Map of Manitoba regional health authorities. *Government of Manitoba.* Retrieved October 2013 from: http://www.gov.mb.ca/health/rha/map.html

Martin-Matthews, A., Tamblyn, R., Keefe, J., & Gillis, M. (2009). Bridging Policy and Research on Aging in Canada: Recognizing an Anniversary. Realizing an Opportunity. *Canadian Journal on Aging*, 28: pp 185-193,

Nova Scotia Department of Health and Wellness (2013). District health authorities. *Government of Nova Scotia.* Retrieved November 2013 from: http://novascotia.ca/dhw/about/DHA.asp

Pankratz, D. (2008). Which best helps the poor: Minimum wages, tax credits or tax exemptions? *The Frontier Centre for Public Policy. 37. 1-14.*

Pauly, M. & Hoff, J. (2002) *Responsible Tax Credits for Health Insurance.* Washington, DC: American Enterprise Institute for Public Policy Research.

Pechman, J. (1987). *Federal Tax Policy* (5th ed.) Washington DC: The Bookings Institution.

Privy Council Office (2013). The constitutional distribution of legislative powers. *Government of Canada Intergovernmental Affairs.* Retrieved October 2013 from:

http://www.pco-bcp.gc.ca/aia/index.asp?lang=eng&page=federal&sub=legis&doc=legis-eng.htm#1

Rummery, K. & Fine, M. (2012). Care: A Critical Review of Theory, Policy and Practice. *Social Policy & Administration.* Vol. 46, No. 3, 321-343. DOI: 10.1111/j.1467-9515.2012.00845.x

Sinha, Marie (2013). Spotlight on Canadians: Results from the General Social Survey: Portrait of Caregivers, 2012. ISBN 978-1-100-22502-9. *Statistics Canada.* Retrieved September 15, 2013 from http://www.statcan.gc.ca/pub/89-652-x/89-652-x2013001-eng.pdf

Statistics Canada (2012). Population by year, by province and territory. *Government of Canada.* Retrieved April 15, 2012 from http://www.statcan.gc.ca/tables-tableaux/sum-som/l01/cst01/demo02a-eng.htm

Statistics Canada (2013). Population and dwelling counts, for census metropolitan areas of census agglomerations, 2011 and 2006 censuses. *Government of Canada.* Retrieved December 2013 from: http://www12.statcan.gc.ca/census-recensement/2011/dp-pd/hlt-fst/pd-pl/Table-Tableau.cfm?LANG=Eng&T=201&S=3&O=D&RPP=150

Statistics Canada (2014).Population by marital status and sex. *Government of Canada* Retrieved May 2014 from: http://www.statcan.gc.ca/tables-tableaux/sum-som/l01/cst01/famil01-eng.htm

Strain, L. (1990). Physician visits by the elderly: Testing the Andersen-Newman Framework. *The Canadian Journal of Sociology. 15: 19-37.* doi: 10.2307/3341171

Tolkacheva, Broese Van Groenou, De Boer & Van Tilburg (2010). The impact of informal care- giving networks on adult children's care-giver burden. *Ageing & Society, Cambridge Journals 31: 24-51.* doi: 10.1017/S0144686X10000711

Turner & Findlay (2012). Informal caregiving for seniors. *Statistics Canada.* Retrieved March 11, 2013 from: http://www.statcan.gc.ca/pub/82-003-x/2012003/article/11694-eng.htm

Victoria Order of Nurses (2009). What is respite care? *Victoria Order of Nurses.* Retrieved January 2014 from: http://www.von.ca/en/caregiver-guide/healthinfosupportservices-respitecare.aspx?guide=3

Warner, G**.** MacDougall, B, & Poss, J. (October, 2013) Using the RAI-HC to assess the effect of a caregiver benefit on caregiver status, Canadian interRAI Conference, Ottawa, Ont.

Williams, C. (2005). The sandwich generation. *Statistics Canada.* Retrieved March 20, 2012 from: http://www.statcan.gc.ca/pub/75-001-x/10904/4212007-eng.pdf

Zucker, Donna M. (2009). How to do case study research. *School of Nursing Faculty Publication Series :University of Massachusetts.* Retrieved March 20 2013 From: http://scholarworks.umass.edu/nursing_faculty_pubs/2.

Appendix A: Key Informant Interview Guidelines

Example questions for key informant interviews, adapted from Keefe, Fancey & White, 2005

1. Do you understand the rationale behind this interview and agree to participate?
2. What, if any, was your role surrounding the implementation of Manitoba's Primary Caregiver Tax Credit or the Nova Scotia Caregiver Benefit? "What was the process of creating the policy?" (Keefe, Fancey & White, 2005, p. 14)
3. What are the ongoing challenges surrounding the caregiver support in your province?
4. How can the support be improved and what are the barriers to improving the support?
5. Do you consider the Primary Caregiver Tax Credit/ The Caregiver Benefit to be a positive means of supporting family/friend caregivers?
6. How could the overall lives of family/friend caregivers be further improved through new and or improved government policies and initiatives?
7. Should the Primary Caregiver Tax Credit/Caregiver Benefit remain a part of their respective province's budgets? Please explain.
8. "How is the program administered? Who has authority/responsibility?" (Keefe, Fancey &White, 2005, p. 14)
9. "How is the program financed?" (Keefe, Fancey &White, 2005, p. 14)
10. "What is the satisfaction level of program users? What should be changed and why? What are the results of cost-benefit analysis" (Keefe, Fancey &White, 2005, p. 14)

Appendix B: Demographic Tables for Manitoba and Nova Scotia

Table A1: Summary of Manitoba Provincial Population by Regional Health Authority

Regional Health Authority	2009	2010	2011	2012
Winnipeg Health Authority	688,533	698,195	710,789	723,491
Prairie Mountain Health Region	161,113	162,713	164,102	165,676
Interlake-Eastern Health Region	119,592	120,661	122,171	124,720
Northern Health Region	71,745	72,650	73,651	74,175
Southern Health Region	173,420	176,051	179,771	183,326
Rural RHAs excluding WHA	**525,870**	**532,075**	**539,695**	**547,897**
Total Population	**1,214,403**	**1,230,270**	**1,250,484**	**1,271,388**

Manitoba Health and Healthy Living (2009). Population Report June 1, 2009. *Government of Manitoba.* Retrieved October 2013 From: http://www.gov.mb.ca/health/population/2009/pr2009.pdf

Manitoba Health (2011). Population Report June 1, 2011. *Government of Manitoba.* Retrieved October 2013 From: http://www.gov.mb.ca/health/population/2011/pr2011.pdf

Manitoba Health (2010). Population Report June 1, 2010. *Government of Manitoba.* Retrieved October 2013 From: http://www.gov.mb.ca/health/population/2010/pr2010.pdf

Manitoba Health (2012). Population Report June 1, 2012. *Government of Manitoba.* Retrieved October 2013 From: http://www.gov.mb.ca/health/population/pr2012.pdf

Table A2: Proportion of Manitoba Population Accessing Caregiver Tax Credit

Year	**2009**	**2010**	**2011**	**2012**
Total Number of Applicants	511	3,039	2,712	2,551
Total Population	1,214,403	1,230,270	1,250,484	1,271,388
Proportion per 100,000	**42.078**	**247.018**	**216.876**	**200.646**

Manitoba Health and Healthy Living (2009). Population Report June 1, 2009. *Government of Manitoba.* Retrieved October 2013 From: http://www.gov.mb.ca/health/population/2009/pr2009.pdf

Manitoba Health (2011). Population Report June 1, 2011. *Government of Manitoba.* Retrieved October 2013 From: http://www.gov.mb.ca/health/population/2011/pr2011.pdf

Manitoba Health (2010). Population Report June 1, 2010. *Government of Manitoba.* Retrieved October 2013 From: http://www.gov.mb.ca/health/population/2010/pr2010.pdf

Manitoba Health (2012). Population Report June 1, 2012. *Government of Manitoba.* Retrieved October 2013 From: http://www.gov.mb.ca/health/population/pr2012.pdf

Manitoba Continuing Care Branch (2013). *Manitoba Health.*

Table A3: Summary of Nova Scotia District Health Authorities Annual Demographic Estimates

DHA Name & Number`	2009	2010	2011	2012
1) South Shore Health	58,480	58,307	58,036	57,679
2) South Shore West	59,792	59,288	58,820	58,215
3) Annapolis Valley Health	82,796	82,923	82,882	82,520
4) Colchester East Hants Health Authority	71,647	71,753	71,944	71,913
5) Cumberland Health Authority	32,121	31,894	31,737	31,464
6) Pictou County Health Authority	46,780	46,787	46,724	46,533
7) Guysborough Antigonish Strait Health Authority	44,268	44,135	43,714	43,201
8) Cape Breton District Health Authority	124,516	123,879	122,907	121,524
9) Capital Health	420,165	426,185	431,692	435,643
Total	940,565	945,151	948,456	948,692

Government of Nova Scotia (2014). Browse Data By Geography. *Nova Scotia Community Counts.* *http://www.novascotia.ca/finance/communitycounts/dataview.asp?gnum=com1011&gnum2=com1011&gname=&gview=3&glevel=com&gtype=&ptype=&gsel=&table=table_d17&acctype=0*

Table A4: Proportion of Nova Scotia Population Accessing Caregiver Benefit

Year	**2009**	**2010**	**2011**	**2012**	**2013**	**Total**
Total Number of Clients	516	413	585	544	**796**	**2,854**
Total Population	940,565	945,151	948,456	948,692	n/a	n/a
Proportion per 100,000	**54.860**	**43.696**	**61.679**	**57.342**	**n/a**	**n/a**

Government of Nova Scotia (2014). Browse Data By Geography. *Nova Scotia Community Counts. http://www.novascotia.ca/finance/communitycounts/dataview.asp?gnum=com1011&gnum2=com1011&gname=&gview=3&glevel=com&gtype=&ptype=&gsel=&table=table_d17&acctype=0*

Government of Nova Scotia (2013) SEAscape database, Continuing Care Branch, Department of Health and Wellness.