The gender logic and effects of instrument mixes: implementing eldercare policy in Canada

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ABSTRACT

Although policy instruments are often conceptualized as technical or neutral tools through which ideas and outcomes are connected, this article focuses on the discursive dimensions of policy instruments in Canada’s eldercare policy to explore their gendered and gendering logics and effects. Using frame analysis, we examine government acts, public reports and policy documents to uncover how different policy instruments at the federal and subnational levels frame caregiving and the caregiver. In doing so, we identify three distinct and contradictory frames – caregiver as resource, caregiver as worker and caregiver as autonomy – and illuminate their effects for gender equality outcomes. By looking at the implementation of eldercare policies in different provinces and across different government levels, we advance a better understanding of the gendered meanings and effects of instruments mixes.

1. Introduction

In the past decade, the issue of eldercare has become a pressing policy issue in Canada. An ageing population, along with changes in family structures and labour force participation, have prompted federal and provincial governments to pursue work-care reconciliation policies to help workers meet the care needs of seniors in their families while remaining active in the labour market. Governments have used a number of policy instruments to implement elder care policies, such as income assistance programs, tax credits, employment protection legislation, and support services for care recipients and caregivers.

Although policy instruments are often conceptualized as technical or neutral tools through which ideas and outcomes are connected, in this paper, we focus on the discursive dimensions of policy instruments, exploring their gendered and gendering logics and effects. Using frame analysis, we examine government acts, public reports and policy documents to uncover how different policy instruments at the federal and subnational levels frame caregiving and the caregiver. In doing so, we identify three distinct and contradictory frames – caregiver as resource, caregiver as worker and caregiver as autonomy – and illuminate how they shape gender equality outcomes. By looking at the implementation of eldercare policies in different provinces and across different government levels, we advance a better understanding of the gendered meanings and effects of instruments mixes.
provinces and across different government levels, we aim to advance a better understanding of the gendered meanings and effects of policy instruments.

The article is organized as follows: First, we discuss the policy implementation scholarship on policy instruments and highlight how the policy and multi-level governance contexts both shape and are shaped by the choice of instrument mixes. We highlight how the political sociology approach to policy instruments, coupled with a gender perspective, provide a useful lens for understanding how policy instruments carry messages about an issue and produce gender effects on policy processes and social relations more broadly. In the second section, we describe our research methods and materials, including our rationale for using frame analysis. In the third section, we examine Canada’s multilevel governance context and highlight how gender effects are reflected and reproduced in the federal government’s policy instruments on eldercare. We show how the structure of Canadian federalism along with the federal government’s diminishing role in social policy are shaping the choice and effects of policy instruments in the area of eldercare in the provinces. We examine how provinces, in an effort to contain health care costs, are using informal caregivers as a resource in the implementation of home care policy. The fourth section examines the fiscal instruments (e.g. tax credits) and leave benefits used by provinces and the federal government to implement eldercare policy. We show how the mix of policy instruments is both individualizing and familizing the ‘problem’ of eldercare, to the detriment of women’s short and long term economic status. The article also reveals how, at the micro-level, the instrument mix used to compensate informal caregiving both shape and are shaped by the gender dynamics of interpersonal relations between the caregiver and care recipient. The article concludes with an overview of the findings and suggestions for future research.

2. Policy instruments and gender policy implementation

In designing policies, governments choose policy instruments to transform policy ideas and intentions into action. Instruments are defined as ‘a set of techniques by which governmental authorities wield their power in attempting to ensure support and effect (or prevent) social change’ (Vedung, 1998, p. 21). From regulation, taxes, and subsidies to ‘soft’ instruments, such as public campaigns and public-private partnerships, policy instruments purposively seek to encourage, discourage or restrain certain behavior from individuals, organizations and sectors. Often, governments use a mix of policy instruments to achieve their policy goals (Howlett, 2011).

Early scholarship on policy implementation focused primarily on understanding the economic or political calculus behind the choice of policy instruments. The visibility of the tool, as well as the delivery mechanisms (e.g. direct or indirect) and degree of coercion are but a few considerations motivating the choice of policy instruments (Salamon, 2002). Researchers would later shift their focus to explaining how contextual factors, such as characteristics of a policy sector and a country’s governmental structure and national policy styles, shape the development and choice of policy instrument mixes (Linder & Peters, 1998; Howlett, 2004; 2011). Other scholars have turned their attention to the intended and unintended effects of policy instruments on policy processes, political systems and the relationship between state and citizens (Schneider & Ingram, 1990).
More recently, scholars have adopted a policy design perspective that links policy instruments to policy goals and ideas (Howlett, 2011). Instead of viewing policy formulation and policy implementation as separate and distinct stages of the policy process, this perspective brings them together by conceptualizing policies as ‘frameworks of ideas and instruments’ with their own ‘underlying patterns and logic’ (Sidney, 2007, p. 85). For Lascoumes and Le Galès (2007), each instrument carries political messages that shape the relationship between the state, the market, and civil society, including the family and community. Rather than simply technical and neutral tools, policy instruments from this perspective have effects that transcend simple cause and effect calculus to ‘structure public policy according to their own logic’ (Lascoumes & Le Galès, 2007, p. 1). They are both technical and social devices that shape relations between the state and the policy’s beneficiaries, as well as social relations more broadly.

The context in which instrument mixes are enacted also shape policy implementation and outcomes. Scholarship on multilevel governance and instrument mixes often emphasize the importance of coordination in designing a coherent and optimal set of instruments to achieve policy goals (Howlett & Rayner, 2007). Yet, in multilevel governance systems, policies are often designed and implemented at different levels involving a multiplicity of institutions using a combination of policy instruments (Bressers and O’Toole, 2005). The choice of instrument mixes is often not a product of rational calculus but rather is shaped by past policy decisions and existing institutional and implementation contexts at different levels of governance systems (Bressers & O’Toole, 2005; Flanagan, Uyarra, & Laranja, 2011). In the case of policy issues that are transversal (Engeli & Mazur, 2018), instruments from different policy domains also interact with one another to shape how policies are put into practice. By looking at instrument mixes in policy implementation, we can get a better sense of how instruments interact with one another to produce tensions and contradictions between ‘goals, rationales, instruments and implementation approaches at different levels and at different times’ (Matti et al., 2016, p. 667).

More importantly, however, by situating the study of instrument mixes in gender and power relations, we can also uncover how implementation may advance or impede gender equality outcomes (Engeli & Mazur, 2018). Feminist policy scholars have introduced gender as an analytical focus in implementation research, shedding light on how implementation and policy tools shape and are shaped by gender relations. While feminist researchers have generally focused their attention on issues related to the formulation of gender equality policy (see Grace, 2011; Mazur, 2016), there is growing interest in understanding how policies are carried out and their intended and unintended effects for gender equality (Verloo & Lombardo, 2007). For example, in their analysis of the role of policy instruments in gender policy implementation, Engeli and Mazur (2018) argue that instruments do more than prescribe policy action; they also determine how the action is implemented and who is responsible for implementing it. They contend ‘instruments contain prescriptions and rules about the actors involved in the implementation process, their functions in the implementation process and the nature of the relationships between these actors’ (Engeli & Mazur, 2018, p. 115). Along with an inclusive and participatory implementation process, Engeli and Mazur (2018) argue that the choice of policy instruments often determines whether or not
gender equality policies produce transformative change or accommodate existing gender relations and dynamics.

3. Methods and materials

In this study, we use frame analysis to uncover the gender meanings and effects of eldercare policy instruments. Frame analysis has been used by feminist policy researchers to study the origins, development and effects of gender equality policies nationally and from a comparative perspective (e.g., Verloo & Lombardo, 2007). Frames are often defined as ‘underlying structures of belief, perception, and appreciation’ (Rein & Schon, 1994, p. 23), that are both cognitive and normative. With respect to cognition, frames help people make sense of the world around them; they act as categories of meaning or understanding that organize our attention to some dimensions of an issue over others (e.g., Hajer & Laws, 2006). But, as categories, frames provide a basis through which to link cause and effect, responsibility, etc. that shape how issues are addressed and who is implicated. In other words, frames are active in the constitution of problems and subjects; they are part of the discursive landscape in which problems are represented and addressed. Typically, frames are conceptualized as nouns, or fixed categories, which produce effects on people. In this paper, however, we take cues from Bacchi’s (2017, p. 21) recent work on categories as verbs to consider the ways in which policy frames, which shape and are shaped by particular practices through instrumentation, produce the very groups they govern. Bacchi’s body of work is distinct from frame theory, focusing instead on representations (e.g., see Bacchi and Goodwin 2016 for a discussion). We are concerned here not so much with what frames are, but rather what they are doing.

To identify the frames produced by policy instruments, we began by mapping the current policy landscape of eldercare in Canada, specifically focusing on policies and programs that made reference to ‘eldercare’, ‘informal’ or ‘family’ caregivers. To do this, we searched for program information on federal and provincial government websites and conducted a search on two data bases – the Canadian Public Policy Collection and the Canadian Research Index. We also examined records of media and parliamentary debates as well as federal-provincial agreements and nongovernment reports written by professional bodies and advocacy groups, such as the Canadian Medical Association and Carers Canada.¹ The aim of our analysis was to uncover how various policy instruments at the national and sub-national levels interact with one another to frame care and to advance or impede gender equality goals. Drawing on feminist work on welfare states, we examined government documents, forms and reports to uncover how instruments used to implement eldercare policy, such as the tax system, worked to frame care in particular ways, reflecting, reproducing, or resisting familial ideas of gender, work and care (Cho, 2014).

The scholarship on caregiving has noted that caring is a gendered phenomenon with the vast majority of caregivers being women. Yet, policies may construct caregiving in gender neutral or gender blind terms, relying on tools and implementation processes that are not gender sensitive, i.e. do not recognize women’s unique positioning in care

¹The materials we reviewed are listed in Appendix A.
work. Although instruments may apply equally to men and women (i.e. are gender-neutral), they may have consequences that are gender-specific since more women are engaged in unpaid care work. Therefore, in studying policy documents, we also examined if and how women and gender were represented in the policy instruments used to implement eldercare policy, both at the federal and provincial levels.

Finally, using a caregiver lens, we apply frame analysis to policy documents to reveal three frames that operate in different jurisdictions: caregiver-as-resource, in which caregiving is constituted as a solution to escalating healthcare costs; caregiver-as-worker, in which caregiving is constructed as an employment issue that needs to be reconciled; and caregiver autonomy, in which caregiving is valued as a contribution on its own, irrespective of familial responsibility, labour market participation, or healthcare provision. As we will demonstrate, each frame is premised on (and reproduces) differing gendered logics and produces distinct gendering effects.

4. The multilevel and gendered context of eldercare implementation in Canada

In Canada, eldercare is located at the nexus of several intersecting policy regimes, including health care, employment, social and immigration policy. Each of these regimes have their own institutional arrangements and policy legacies that help shape the tools and implementation of eldercare policy. For example, as a liberal-residualist welfare state regime, Canadian social policy is largely characterized by means-tested social assistance, modest benefits and strict entitlement criteria (Esping-Andersen, 1990; Findlay, 2015). Due to Canada’s federal system, the implementation of eldercare policy is also fragmented and decentralized, involving different national, regional and local authorities. Social policy, including eldercare, is designed and implemented at different levels involving a multiplicity of institutions using a combination of policy instruments. Constitutionally, the provinces play a central role in the area of social policy, such as education, health and social services, while the federal government has fiscal responsibility in these areas through its spending powers. The federal government is also responsible for policy areas that directly or indirectly interplay with eldercare, such as old age security, tax policy and employment insurance.

Since the 1950s, federal funding to provinces and territorial for health and social services has evolved from conditional cost-sharing grants tied to national principles and standards, to block funding with limited or no conditions or national standards (Gauthier, 2012, p. 10). Today, due to the ‘social policy architecture of Canadian federalism’ (Bezanson, 2018, p. 176), the majority of social programs are delivered by the provinces and territories, with very little steering on the part of the federal government. In the case of eldercare, this explains why Canada lacks a national caregiving strategy; instead, eldercare is governed mostly by intergovernmental and bilateral agreements between the federal and provincial levels of government. This also means that the policy framework, in which different jurisdictions favour different policy instruments, has resulted in multiple eldercare frames, as discussed below.

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The federal government is responsible for the delivery of home care services to on-reserve First Nations and Inuit communities, and members of the armed forces and the RCMP.
To date, the main federal-level initiative for family caregivers is the Compassionate Care Benefits Program, discussed in-depth below, which is governed by the Employment Insurance Program. The CCBP ties eligibility and benefits to employment status and earnings, thereby framing eldercare as an issue that needs to be reconciled with paid labour. Instead, the federal government has fostered bilateral agreements with the provinces. In 2016, the Liberal government set aside $11.5 billion over 10 years in targeted funding for home care and mental health. By May 2018, all provinces and territories signed separate, bilateral agreements with the federal government to target funding in specific areas of home care. Neither the federal government’s Statement of Principles on Shared Health Priorities (Canada, 2017) nor bilateral agreements mention gender-related issues; instead, eldercare is problematized in terms of escalating health care costs. Although eldercare and caregiving is highly gendered in terms of who provides the care and who shoulders the social and financial burdens of care work, only Alberta and New Brunswick’s agreements briefly reference the caregiving burdens of women. In general, however, all agreements, to varying degrees, conceptualize the caregiver in gender neutral terms and as a resource needing services to better equip them to perform their caregiving duties. The caregiver-as-resource frame is one that views the family at the ideal setting for care provision, with little attention to the unequal gender relations that underpin the institution (Guberman & Maheau, 2002).

The intergovernmental context of eldercare policy implementation also does not provide favorable conditions for gender-sensitive outcomes. Feminist policy scholars have highlighted how executive federalism and intergovernmental relations, characterized as ‘decision-making behind closed doors’ (Sawyer, 2014, p. 361), privileges territorial or jurisdictional considerations and identities rather than gender, race or class (Findlay, 2015). In the case of eldercare, this context worked to marginalize the voices of women’s groups, caregiver advocates to shape the implementation process and outcomes. It also shut out those actors working at the front line of eldercare, such as social workers, physicians, and nurses, who have called on the federal government to take a leadership role in home and elder care through the enactment of a pan-Canadian Caregiver Strategy (Carers Canada, 2013).

Instead of a national strategy, block funding arrangements and federal-provincial bilateral agreements shape the broad conditions of eldercare implementation in Canada. Today, support programs and services for caregivers remain the purview of provincial and territorial governments, implemented by regional bodies ‘mandated to oversee the contracting out of service delivery to competing not-for-profit and for-profit home and public-sector care providers’ (Neysmith, 2012, p. 304). The transfer of decision-making authority and oversight responsibilities to regional bodies along with the diversity of service delivery mechanisms for home care has contributed to a patchwork of services and care levels both across and within provinces. In Ontario, for example, access to services has been described as winning the ‘postal-code lottery’ in which patients receive publicly-funded services based on where they live and how generous their local agencies are funded (Barker and Church, 2016). Federal-provincial jurisdictional and funding arrangements at the macro level have led to considerable variations in the provision of care, undermining a pan-Canadian social citizenship (Bezanson, 2018).
In all provinces, governments are shifting care eldercare provision away from hospitals and long-term facilities and toward the home and community. Yet, while demand for homecare is growing, access to publicly-funded home care services continues to be uneven and limited. Canadian women living in rural and remote areas of the country as well as members of immigrant and ethno-cultural minority communities face additional obstacles when accessing services and resources (Canadian Home Care Association, 2006). To fill the gap, provincial home care policies turn to the unpaid labour of family caregivers. In 2012, family caregivers provided roughly three-quarters of the care to seniors while provincial home care services provided approximately one-quarter (Health Council of Canada, 2012). Despite increased attention and stated commitments to home care services, the idea of the ‘family’ as the ideal site for care continues to undergird provincial approaches to eldercare that also promote the private provisioning of care for those who can afford it. As such, these policies, which simultaneously familise and privatize eldercare, do little to disrupt gendered divisions of labour and the gendered economic consequences of family caregiving.

The degree to which the role of family caregivers is recognized in home care policy also varies from province to province. Today, only Manitoba recognizes informal caregivers through its Caregiver Recognition Act. Introduced in 2011, the Act recognizes the pivotal role caregivers play in society and acknowledges them as ‘individuals with their own needs within and beyond the caring role’ (Manitoba, 2011). It also legislated the creation of a caregiver advisory committee to provide advice and develop recommendations on caregiver supports and services. This ‘caregiver autonomy’ frame, however, is found only in Manitoba and Nova Scotia. In most provinces, informal caregivers are discussed in relation to home care and primarily regarded as a resource in broader government efforts to reduce institutionalized care and support ‘ageing-in-place’. For example, Saskatchewan’s Home Care Policy Manual explicitly states home care ‘encourages and supports assistance provided by the family and/or community’ (Saskatchewan, Ministry of Health, 2015, p.5). Support services for caregivers take the form of education, training, support systems and temporary respite. These policies are not geared towards relieving the family from their caregiving duties; instead, they are aimed at ‘increasing the caregiver’s ability and competency to support his or her relative, while recognizing the importance of ensuring their emotional and psychological wellbeing’ (Guberman et al., 2006, p. 75). Gender differences in caregiving duties are also not recognized in provincial home care policies. Although Canadian scholarship and national statistical data continue to show that women’s economic status is negatively affected by family caregiving, home care policies write out women by not containing gender-specific measures to address this problem.

5. Caregiver as resource: individualizing and familising effects of tax credits

In recent decades, the federal government has moved away from direct social spending and turned to the tax system to provide financial assistance for family caregivers. Federal tax credits are an attractive policy tool for compensating unpaid care work for a number reasons. First, they allow the federal government to intervene in matters of provincial jurisdiction. As Brooks (2016, p. 64) explains, ‘because [tax credits] are an
exercise of the federal government’s spending power and because they are direct transfers to individuals administered by the Canada Revenue Agency (CRA), the federal government does not have to negotiate with the provinces and territories over their design or their delivery.’ Second, tax credits reduce the political pressure for social programs whilst serving the broader political project of a private-sector welfare state (Brodie, 2007; Brooks, 2016). Finally, the process of enacting tax credits is often opaque to the general public, and is characterized by limited consultation and input from relevant stakeholders. Involving just the Finance Department and Minister, tax credits are easier to enact since they do not go through the same onerous budgetary planning process as do spending programs (Brodie & Bakker, 2007).

With respect to eldercare, the federal government offers a non-refundable tax credit – Canada Caregiver Credit (CCC) – to incentivize family caregiving in the home setting. However, tax relief is only available for the care of ‘infirm dependents’, thus recognizing only care that is viewed as socially useful and that ‘relieves the health and welfare system of work it might otherwise perform’ (Kershaw, 2002, p. 1959). This effectively excludes seniors who are dependent on others to help them with activities of daily living or health maintenance functions. Moreover, by using a medical definition of ‘dependency’, health care professionals become gatekeepers to the program since caregivers have to rely on them for signed statements confirming the nature of the impairment and its duration.

The non-refundable nature of the tax credit also means that their value is only available to individuals with higher taxable income, most of whom are men. As such, it does not recognize that caregivers are often women with lower incomes, which may help explain why in 2010 only 1% of tax filers applied for the credit, 75% of whom were men (British Columbia Law Institute, 2010). That same year, men benefitted from the credit in larger numbers than women, receiving 60.6% of the tax expenditures for the dependent caregiver credit while women received 39.4% (Lahey, 2015). Inaccessible to low-income earners, the caregiving tax credit further undermines the caregiver’s financial independence and ‘reinforce[es] the breadwinner/caregiver dyad that underlies much public policy’ (British Columbia Law Institute, 2010).

Other eligibility requirements also reflect and reinforce gender inequities. For example, the care recipient and caregiver have to be in a familial relationship, thus encouraging existing gendered expectations of and involvement in care work in the family. Moreover, the Canada Caregiver Credit is not linked to the duration or nature of care work provided by the caregiver. Instead, eligibility is also contingent on the care recipient’s income as well as their dependence status. The care recipient has to have a reduced income in order for the caregiver to receive the credit. For example, in 2017, if the qualifying care recipient had an income over $16,163, the credit was lowered a dollar for every dollar that was earned over that amount. By making the earnings of the care recipient an eligibility requirement, the caregiver tax credit emphasizes the financial aspect of caregiving rather than recognizing and compensating the unpaid labour performed by mostly women caregivers.

Provinces have also included tax credits as part of their instrument mixes for eldercare. Like the federal CCC, provincial tax credits frames the caregiver and caregiving in gender-neutral terms, masking eligibility criteria that work to reinforce existing gender inequalities. Most of them are non-refundable and therefore not beneficial to low-income women who do not pay sufficient taxes. Moreover, tax credits also do not
compensate for the value of the unpaid labour performed; instead, the level of compensation is directly linked to the care recipient’s income in that it is reduced dollar-for-dollar by the dependent’s net income above a certain threshold. Only two provinces – Quebec and Manitoba – have introduced refundable tax credits, meaning that women who do not have taxable income could also receive a subsidy.

Moreover, in Quebec, the credit amount received by the caregiver is not tied to the care recipient’s income, thus providing greater recognition to the economic status and labour performed by the caregiver. However, like the federal tax credits, Quebec uses kinship and medically-based measures of ‘dependency’ as eligibility criteria. The credit is only available to caregivers who provide support to a relative who is dependent due to a physical or mental infirmity, thus constructing the need for care as the lack of autonomy to function independently. It also constructs the care relationship ‘as a unidirectional relationship in which an active and independent caregiver provides care to a passive, dependent and burdensome care-receiver’ (de São José, 2016, p. 60). Moreover, by including the ‘dependency’ requirement, Quebec’s caregiving tax credits continue to position the caregiver as an independent, healthy and able-bodied agent without health needs of their own (Fine & Glendinning, 2005).

Like Quebec, Manitoba provides a refundable tax credit (up to $1,400) to primary caregivers that is not attached to the care recipient’s income. An important difference, however, is that kinship is not an eligibility requirement and caregivers are allowed to claim the credit for multiple care recipients. Moreover, unlike the Quebec and federal tax credits, Manitoba’s definition of caregiver focuses on the labour involved rather than the care recipient’s dependency status (Funk, 2012). However, while the Manitoba tax credit uncouples care from kinship ties, it continues to situate the inter-personal relationship of care within the domestic domain where gendered activities, relations and encounters persist.

6. Caregiver as autonomy: provincial caregiver pay program

Although tax credits remain the most popular tool for both provincial and federal governments, some provinces have introduced other measures to compensate caregivers. While federalism can result in a patchwork of social services and protections, it can also provide opportunities for provinces to experiment with different policy instruments. Nova Scotia, for example, introduced a caregiver allowance to directly compensates caregivers who provide over 20 hours a week of assistance to low-income care recipients with a high level of disability or impairment. The care recipient’s eligibility is assessed by a Care Coordinator. To receive the $400 monthly allowance, caregivers do not have to be family members but must be in an ‘ongoing care relationship with the person receiving care’. From the government’s perspective, the monthly allowance, which supports the sustainability of the caring relationship, has been successful in reducing health care costs. However, like other benefits program, family caregivers often find it difficult to qualify for the allowance due to the program’s stringent definition of dependency status and the gatekeeping role of Care Coordinators who assess the care recipient’s eligibility (CBC News, 2009).

From a gender perspective, Nova Scotia’s Caregiver Benefits Program is advantageous since it recognizes and directly compensates women for the labour they perform rather than their family status or income. It thus frames eldercare around the autonomy
of the caregiver. Expanding caregiver status beyond family members defamilises care as it reduces women’s family care obligations and allows them to seek and maintain full-time employment. From a life-course perspective, however, this policy may lead women to reduce work to provide care, thereby jeopardizing their future, long-term financial security. As Keefe and Rajnovich (2007) explain, ‘[a] policy paradox emanating from financial support policies for caregivers is that the very policy designed to support all caregivers, many of whom are women, may have the undesirable life course effect of poverty, limited pensions, and dependency.’ Finally, the allowance reflects a residualist model of social policy since it targets care provision to low-income care recipients. The program’s underlying assumption is that higher-income earners can purchase support in the market and therefore do not need to rely on the state or the family for support.

In the past decade, other provinces have implemented direct compensation measures for family caregivers through existing self-managed care programs. Also called consumer-managed care, these programs allow eligible individuals to receive funds directly from provincial ministries of health to purchase their own home support services. Care recipients are treated as consumers or clients who can choose services from various providers. While all provinces have self-managed care programs, only Manitoba, British Columbia and Nova Scotia permit payments to family caregivers but under exceptional circumstances. In these three provinces, family members can receive payment if regional health authorities determine that no other care worker is available or able to meet the unique needs of the care recipient due to cultural, linguistic or geographical reasons or because of the nature of the care that needs to be provided. In general, however, the program’s exclusion of payment to family members reflects and reinforces the idea of family caregiving as a ‘labour of love’ or a natural extension of kinship responsibilities (Evers, 1994; Keefe & Rajnovich, 2007), distinct from the care that can be obtained in the private sphere.

7. Caregiver as worker: the federal compassionate care benefits program

In the area of child care, full time workers in Canada have access to paid maternity and parental leaves, as well as leaves to take care of critically ill children through the federal government’s employment insurance program. For workers taking care of older adults, however, there is only one benefits program that covers care provision for palliative care patients. Introduced in 2004, the federal Compassionate Care Benefits (CCB) program offers income support to family caregivers who need to temporarily interrupt their employment to care for a gravely ill family member. The program was enacted in response to recommendations of a 2002 report on the future of Canada’s health care system, which called for greater recognition and support for ‘informal caregivers’ who were increasingly providing support to family members being treated in the home (Romanow, 2002). When first introduced, the CCB program provided 55% of average insured earnings (with a maximum of $435 per week) for a 6-week period to workers who were providing care or support to a family member who is at risk of dying within 26 weeks. To be eligible for the benefits, applicants were required to have worked a minimum of 600 hours in the previous 52 weeks. They were also required to be a designated family member and have a physician’s certificate that the patient was gravely ill and at risk of dying within 26 weeks. In 2015, the
Conservative government extended the benefits from six weeks to six months and expanded the formal designation of family to include close friends.

As a work-care reconciliation policy, the CCB program aims to ‘... help families perform tasks that are fundamental to society and to make it easier for men and women to perform their family responsibilities while being active in the labour market’ (Knijn & Smit, 2009, p. 495). Administered through the EI program, the CCB program’s formal intention is to provide income support to full-time working caregivers, irrespective of gender, who need to take time off work to care for a dying family member. It is premised, however, on the gender-neutral model of the ‘adult-worker’, which links social benefits for both men and women to their participation in the formal labour market (Daly, 2011; Lewis & Giullari, 2005). Based on the adult male experience of employment (i.e. continuous, full time employment), this model serves to obfuscate women’s different employment patterns and levels of engagement with unpaid care work (O’Connor et al., 1999; Sainsbury, 1999). In Canada, women’s full time participation rate in the labour force continues to be lower than men’s (Statistics Canada, 2016). Moreover, women hold 76 per cent of Canada’s part-time jobs, thus making them ineligible for the EI’s compassionate care benefits (Moyser, 2017). Like other benefits programs attached to labour market participation, such as pensions, sick time and vacation leaves (Fast, Eales, & Keating, 2001), the CCB program does not recognize or mitigate for gender and other differences in work patterns, thus disadvantaging women economically, both in the short-term and the long-term (e.g. reduction in potential pension benefits). Because it is designed for ‘traditional’ workers, the program shuts out marginalized workers who perform precarious labour (i.e. temporary and part-time work) and who are disproportionately comprised of aboriginal, immigrant and minority women.

The gendered realities of work and care may account for the low uptake in the CCB program since its introduction in 2004 (Canada, 2015). The dynamics of the program’s implementation ‘on the ground’ also serves to limit uptake. The caregiver-as-resource model is activated at the micro-level, in needs assessment processes and interactions among frontline bureaucrats, caregivers and care recipients. In hospital settings, as well as in the context of home care, the dependent adult is regarded as the client while the family caregiver is viewed as a resource to help care for the client. Frontline bureaucrats, such as nurses and social workers, do not view or interact with family caregivers as potential clients of health and social services (Guberman et al., 2006). Also, social workers in palliative care settings are sometimes reluctant to discuss the program with family caregivers who may not be mentally or emotionally prepared to accept a loved one’s death is imminent (Williams et al., 2009). The application process is also a hindrance to program uptake. Like other employment insurance benefits, eligible caregivers are required to submit their applications for compassionate benefits by mail or online, leaving them to navigate the paper work on their own, during a very stressful time. They often abandon their attempt to apply for benefits because they find it too stressful or time consuming (Williams et al., 2009). Instead, they either choose to take vacation leaves, re-arrange their work schedule, or opt out of the labour force altogether. These options have long-term consequences for women’s economic and social well-being as it can lead to burn outs and loss of pensionable earnings.
8. Discussion and conclusion

The article provides additional support that, as Lascoumes and Le Galès (2007) contend, policy instruments are not simply neutral technocratic tools used to implement policy. Rather, they have an underlying logic that frames a policy issue and shapes the social and political relations that surround it. The case of Canada’s eldercare policy contributes to this scholarship by bringing to bear the added dimension of gender for understanding the intended and unintended effects of instrument mixes. We show how at the macro, meso and micro levels, policy instruments in eldercare reflect and reproduce gendered relations of power as they simultaneously individualize and familise care. At the macro level, Canadian federalism and trends in multi-level governance have led to greater devolution of authority to the provinces in social policy. In this context, rather than pass legislation or develop a pan-Canadian eldercare strategy, the federal government is increasingly relying on fiscal instruments, such as taxes, as well as the Employment Insurance program to attain its social policy objectives. In the provinces, where we see a more varied mix of instruments, family caregiving is represented as a resource for containing rising health care costs. At the sectoral level, provinces are using the ‘family’ and the ‘community’ to deliver care to older people as they shift care provision away from publicly-funded institutions, such as hospitals, to the home. As they reduce social services, provinces look to tax credits to provide financial assistance to family caregivers. Together, these measures have privileged territorial identities and priorities rather than women through a pan-Canadian social citizenship.

As we show in this article, however, the burdens and benefits of these measures are distributed along gender lines. Given the differences in men’s and women’s engagement in paid and unpaid work, women are less likely to benefit from tax credits and care benefits. By treating the caregiver as a resource and in the context of kinship ties, these instruments construct eldercare as a private matter and financial burden rather than an issue inextricably linked to women’s economic and social well-being. At the same time, by requiring the caregiver be a family member, policy instruments like tax credits also encourage the familisation of eldercare, especially for low-income seniors who do not have the funds to secure services in the private market. Moreover, implemented through the existing tax code and employment insurance scheme, these instruments shield the gender effects of eldercare from public view, limiting the level of public engagement and activism on the part of women’s groups. While caregiver advocacy organizations do exist in Canada, they are less influential than their counterparts in other countries. Finally, at the micro-level, these instruments shape the power relations within and around the care relationship. They construct the care recipient as a passive dependent rather than an active agent who can exert control and choice in their care.

Overall, our study of eldercare implementation in Canada shows the usefulness of an instrument mix approach for uncovering the dynamics and outcomes of gender policy implementation within a multilevel governance context. It uncovers how various instruments enacted by different levels of government represent family caregivers in contradictory ways, as either workers, taxpayers, or a resource in the provision of eldercare. These representations interact with one another to reinforce rather than uproot unequal gender relations. Together, they simultaneously maintain the family, conceptualized in traditional, heteronormative terms, as the central site of eldercare
while upholding the gender-neutral adult-worker model of social policy that ties benefits to employment status. These contradictory gendered logics reinforce women’s caregiving responsibilities while at the same time rendering invisible the female face of caregiving in policy deliberations and advocacy work.

While a number of policy measures might improve gender equality, such as decoupling employment status with support for caregivers, establishing national standards, pension reform, and so on, perhaps the key finding of our study is that the needs of the caregiver must be central to every step of policy development, from problem identification to policy design to implementation and evaluation. Doing so will ensure not only that caregiving is recognized and valued, but might also open opportunities to trouble the gendered division of care work.

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Appendix A

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