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Elder Care: the Nexus for Family, Work and Health Policy

by

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Introduction

Almost everyone will experience elder care, either as recipients or as caregivers. The provision of such care impacts the caregiver, the caregiver family, the care receiver, the workplace and society as a whole. Public policy is challenged to examine the issues of elder care through the nexus of family, work and health policy, rather than dealing with these policies individually. The expenditures in one policy field can have consequences for the costs and outcomes of all the other policy fields. The growing need for elder care also changes the traditional categories of public and private, and suggests redistribution of responsibilities held by individuals, families and governments.

The issues for policy making

Typically, governments have not intervened in family matters and in individual lives. Thus, persons 65 and over have responsibilities for themselves, and families provide informal care to family and friends voluntarily. Aging policy has been residual; public services, beyond the capacities of families and individuals, complemented informal care services. Such public policies were considered a demogrant, benefiting the entire aged segment of the population.

Elder care, however, requires the simultaneous examination of policies that favour or hinder the working of the care system, with many providers. It also is necessary to take a life cycle perspective, in order to ensure that caregivers do not accumulate disadvantage that will later impose individual or public costs. The impacts can be long term, intergenerational and society-wide. Furthermore, the provision of elder care can affect private business productivity and pro-fits as well as both the public and private sectors of the economy.

In order to disentangle the web of potential effects, this paper examines the data on elder care from the micro perspective of the senior, the caregiver, the worker and the employer as well as the macro view of the labour force, caregivers pool and the economy.

Impact on care receiving seniors

The number of seniors has more than doubled in the past 25 years and is projected to keep growing in the coming decades. Table 1 shows the increasing elderly population according to age groups.

Life expectancy has increased. Women born in 1941 can expect to live four years longer than women born in 1921. Though all seniors benefit from some care, those 75 and over consume more care. Therefore, the growth in this segment of the population is a key factor. Seniors living longer will rely on family for informal care and their larger numbers will increase the com-petition for limited formal care.

Table 1
Elderly Canadians, by age group, 1996-2026

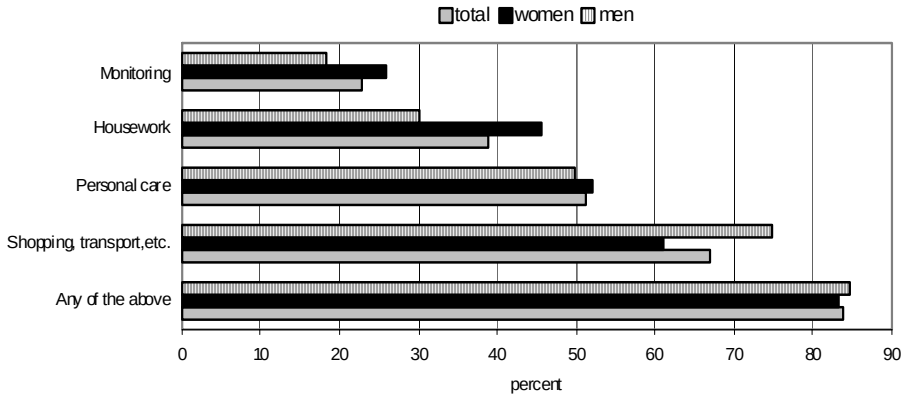
age group	1996 '000	2006 '000	2016 '000	2026 '000
65-69	1130.3	1222	1906.8	2415.3
70-74	981.4	1029.2	1362.8	1968.3
75-79	704.9	856.8	954.4	1512.9
80-84	467.6	627.0	685.7	938.3
85-89	239.5	351.9	450.7	524.3
90 and over	120.0	215.1	330.5	400.6
65 +	3643.7	4302	5690.9	7759.7
75+	1532	2050	2421.3	3376.1

Source: Statistics Canada 1996

In 1996, of the 3.4 million seniors who lived in the community, more than 750,000 received informal assistance with their everyday activities because of a long-term health problem or disability. The need for support varies considerably by age and by individuals. Personal care is the most demanding on the caregiver. Because women outlive men, such personal care is often given and received by women. Figure 1 shows different types of care received by elderly women and men.

A US study estimated that the average care recipient receives informal caregiving services worth approximately $21,000 per year [Arno and Levine 1997]. There is also a growing trend to combine both informal and formal care.

Figure 1
Assistance received by seniors, Canada, 1996
data: Statistics Canada 1996



Impact on the caregiver pool

Between 70 and 80 percent of the support and care for elders who live at home is provided as unpaid work by family members. The aging of the Canadian population suggests that the need for care is likely to be greater in the future. The increase in the absolute numbers of seniors, by itself, is not necessarily an indication of unsupportable demands for care. Rather, it is the balance between caregivers and receivers that matters.

For purposes of simplicity, the cohorts between the ages of 40 and 64 will be considered the caring generation while those 75 and over will be considered the care receiving one (though not all in the former category give care nor do all in the latter group receive care). In Canada, the demographic pressures arise because the cohorts that follow the baby boom cohorts are smaller. The baby boom generation will swell the caring generation between 2006 and 2016. Therefore, the ratio between caregivers and persons 75 and over is favourable early in the century but will not continue to be so once the baby boomers themselves age and are dependent upon the baby bust generation for care [Brink 2000].

Impact on caregivers

Caregiving tasks fall into two categories: instrumental activities such as preparing meals, doing housework or providing transportation; and personal care activities, such as bathing, dressing, toileting and feeding. These responsibilities require significant commitment of time and energy.

About 2.1 million Canadians looked after older family members or friends in 1996. Six out of every ten of these caregivers were women and they spent five hours a week on care-related tasks, compared to three hours a week for men. Both male and female caregivers were, on average, in their mid-40s with a concentration in the 45-65 year group. Over two-thirds were employed in 1996. Considerable care is also given by seniors aged 65 and over to their spouses, friends and neighbours.

Almost half of assistance with instrumental activities was given to parents and parents-in-law (47 percent), while 24 percent went to friends, 13 percent to members of the extended family and 5 percent to spouses [Cranswick 1997]. Due to the intimate nature of these tasks, they are generally provided by female relatives, and usually for women recipients.

The vast majority of caregivers indicated that caregiving is rewarding. However, the caregivers that spent the most time experienced the highest level of personal consequences and emotional burden. Eleven percent of caregivers felt that they do not have enough time for them-selves, while almost 30 percent said they rarely or sometimes felt that way [Cranswick 1997]. American data shows that the average length of caregiving is about eight years, with roughly one-third providing care for ten years or more [Metropolitan Life Insurance Company 1999].

In the future, there may be more demand for care than the current pattern of caregiving can provide, and there are few options for increasing informal care. Women of advanced age rarely receive personal care from men. Some experts suggest that the primary caring role may fall to others, such as siblings and grandchildren, in future. The shortage of caregivers is already evident, as indicated in the results of a survey from the Canadian Aging Research Network [CARnet 1996], which showed that while the majority of caregivers (60 percent) assisted only one elderly relative, almost one-third (32 percent) helped two and a minority (8 percent) helped three or four. Furthermore, two generations may separate the carer and care-receiver. Almost 10 percent reported caring for their grandparent [McBride-King 1999].

More than half of Canadians 15 years and older who do not live with one or both parents live within 50 kilometres of them – most within 10 kilometres. However, as many as 23 percent live beyond 1,000 kilometres [McDaniel 1994]. Among seniors aged 70 and older with children, only 11 percent have no children living within one-and-a-half hours of travel time [Rosenthal 1987].

Given the shrinking labour pool, there will be greater demands for labour mobility. Since there is likely to be a 30-year difference between parent and child due to older age of first birth, children are likely to be 45 or younger when parents are 75. Labour force mobility is higher among younger families as they establish their careers.

Also, immigrant boomers may not have their parents close at hand. A study by the National Council for Aging in the US estimates that the number of persons who provide long distance care is expected to double in the next 15 years [National Council on Aging 1997]. The provision of daily personal care by a child is ruled out when caring is at a distance.

Impact on families

Sixteen percent of women living with their spouse and children are caregivers, while 14 percent of caregivers live with a spouse only and 12 percent live with their children only [Cranswick 1997]. Thus, most caregivers have family obligations in addition to caregiving responsibilities.

Fifteen percent reported that they nearly always feel stressed about combining caregiving while trying to meet family and work responsibilities. A further 36 percent feel that way rarely or sometimes. Women are more likely to be stressed about the impact of caregiving on family and work than men (18 and 12 percent, respectively).

Most caregivers experience some disruption in their lives. Data from the General Social Survey [Statistics Canada 1996] shows that 45 percent made changes to their social activities, 25 percent changed their holiday plans, 44 percent incurred extra expenses, 29 percent experienced change in their sleep patterns and 21 percent had their health affected. The intensity of caregiving also caused 6 percent of caregivers to move in with the person being helped and 12 percent to move closer to the person being helped,

as shown in Table 2. The impact on health status due to stress, changed sleep patterns and health impacts is not considered under health policy, which benefits from the informal care provided by family members.

Table 2
Percentage of caregivers who agree that helping others caused them …

	Total	Men	Women
To make changes in social activities	45	44	47
To change holiday plans	25	25	26
To change sleep patterns	29	26	31
To incur extra expenses	44	46	42
To affect health	21	12	27
To move in with person being helped	6	5	7
To move closer to the person being helped	12	9	15

Source: Statistics Canada 1996

The need for respite care is evident. Fifteen percent of caregivers (equal proportions of men and women) wish someone could occasionally take over their caregiving. Since caregivers incur extra expenses, 15 percent of women and 16 percent of men reported that financial compensation for their unpaid caregiving would be helpful.

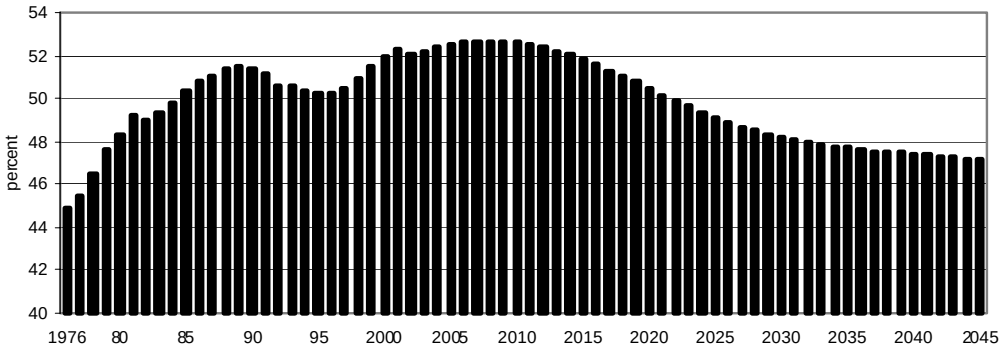
A US study showed that, on average, caregivers incurred US $19,525 in out-of-pocket expenses each year for two to six years. The highest average amount expended by caregivers each month was for assistance with rent or mortgage (US $364) followed by expenses for home care professionals (US $322). The use of supplementary home care professionals over and above informal care is further proof of the mismatch between need and available support [Metropolitan Life Insurance Company 1999].

Impact on the labour pool

Due to demographic reasons, the labour force as a percentage of the total population is projected to decline after 2010, as illustrated in Figure 2. Much of the gains in the labour force in the past were due to the increasing labour force participation of women.

The high share of informal care was possible because of the size of the baby boomer generation. Following generations will not be as large. As the baby boom generation reaches old age, the dependency ratio between the working population and the elderly will rise. With more highly educated women and more of them working, the potential for informal care will fall and the caring professions will be starved for workers, since care is largely provided by women. Since both components of the care sys-tem will experience shortages, a simple shift in allocation of resources from the informal to the formal parts of the system will not eliminate the problem.

Figure 2
Labour force as percentage of the Canadian population, 1975-2045
data: Socioeconomic studies, HRDC



Impact on workers

Though estimates vary, a significant pro-portion of caregivers are employed. Fifteen percent of employed women and 10 percent of employed men are caregivers [Statistics Canada 1996]. According to an earlier survey, 46 percent of caregivers provide elder care. Of these, 25 percent provided personal care [CARnet Work and Family Survey 1993].

In a Conference Board of Canada survey, one in four Canadian employees reported that they or others in the household provided care or support to an elderly (86 percent) or disabled family member; in 1989, the figure was one in five [Macbride-King and Bachman 1999]. About half were between the ages of 35 and 54. On average, 28 hours a month were spent on all elder care; however, an average of 60 hours were spent by those providing personal care [McBride-King 1999].

In 1997 in the United States, nearly 25 percent of all households have at least one adult who has provided care for an elderly person during the past 12 months. Over the current decade, the total number of employed caregivers in the US is expected to increase to between 11 and 15.6 million workers – roughly one in ten employed workers [Wagner 1999].

Half of employed caregivers (55 percent of whom are women and 45 percent men) note that caregiving affected their work, specifically, coming to work late or leaving early (34 percent of female caregivers and 31 percent of male caregivers) or having to miss at least one day of work (34 percent and 24 percent, respectively) [Cranswick 1997].

Table 3
Percentage of caregivers who agree that helping others caused them …

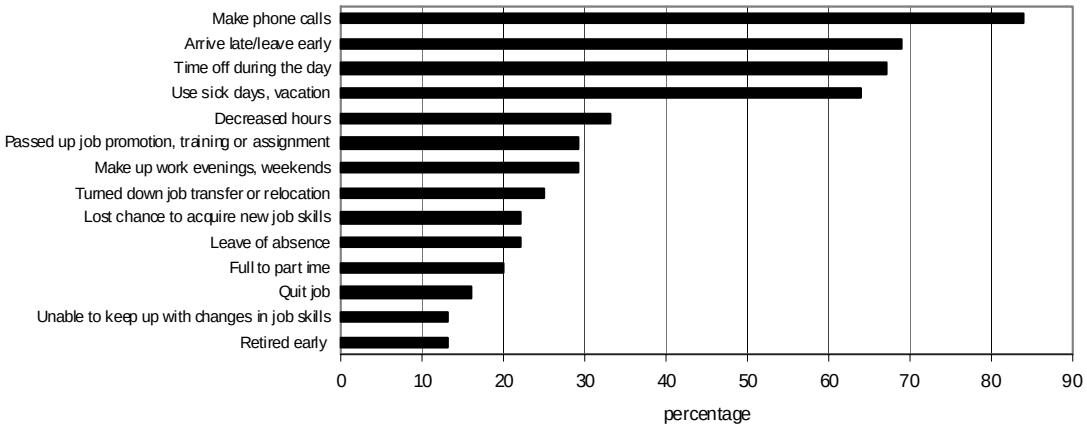
	Total	Men	Women
To postpone plans to enroll in an education or training program	6	5	7
To have repercussions at work	50	45	55

Source: Statistics Canada 1996

In 1995, women working full time lost an average of seven days to personal or family responsibilities compared to just under one day for men. Statistics Canada found that absenteeism by women increased from six to seven days from 1993 to 1995, with the most significant reason being the need to handle family responsibilities. A slightly higher percentage of women (7 percent) compared to men (5 percent) postponed their plans to enroll in an education or training program [Statistics Canada 1996].

Research shows that 17 percent of caregiving employees in Canada who were offered promotions turned them down and that 25 percent refused transfers because of family responsibilities [McBride-King 1999]. Data from the United States provides a similar but more detailed picture of the impact of caregiving on work. The impacts fall into three groups: the inability to maintain or improve skills, the slowing or termination of a career and repercussions at work affecting productivity (Figure 3) [Metropolitan Life Insurance Company 1997]

Figure 3
Work adjustments due to caregiving, United States, 1997



Women have significantly increased their participation in the workforce and so have parallel "caring careers" where they provide care in serial fashion to children, parents and spouses. The impact on women's careers includes lower savings and

pensions due to foregone promotions or advancement in addition to the stress of combining work and caregiving. There are some indications that women have interrupted work years, that they have jobs rather than careers and that they undertake part-time work more often than men. Research shows that women providing personal care have more short-term job costs, long-term career costs and personal costs [Gottlieb, Kelloway and Fraboni 1994].

According to the MetLife Study of Employer Costs for Working Caregivers, 23.2 percent of all US households with telephones (numbering 22.4 million households) were involved in caregiving. About two-thirds of caregivers (64.2 percent) were employed, the majority of them full time (51.8 percent). More than 14.4 million employed caregivers were balancing work and caregiving. The responsibilities of caregiving have a direct impact on employee productivity and on those who work with them. About half of those balancing work with caregiving modify their work schedules, come in late, leave early, take long lunches, make or receive phone calls at work related to care-giving, miss work to take the care receiver to appointments, or take leave to deal with sudden crises. Few changed from full-time to part-time work or took a less demanding job (7.3 percent). Eleven percent took a leave of absence [Metropolitan Life Insurance Company 1997].

Because caregiving workers are typically middle-aged and at their highest earning power, the impact on lifetime earnings and pensions are high. In the United States, the total loss in wage wealth (the present value of lifetime wages calculated as of the date of retirement) was substantial – an average loss of US $566,443 (median US $243,761). The average annual pension benefits fell by US $5,339 annually as a result of caregiving, resulting in a US $67,202 reduction in pension wealth on average over the retirement years [Metropolitan Life Insurance Company 1997].

The impact of caregiving on business and the economy

A recent study set the value of unpaid caregiving for adults in the United States at US $196 billion a year, estimating nationally what it would cost to care for chronically ill or disabled adults if family and friends did not provide such services [Arno and Levine 1999].

In the US, productivity declines are anticipated for 8.7 million employed caregivers. One-tenth of working caregivers give up work permanently (3.6 percent take early retirement and 6.4 percent give up work), requiring hiring and training of new personnel. The costs to business are high because caregiving workers are experienced and at the peak of their earnings. The annual cost to employers in the United States has been estimated at between $11 billion and $29 billion [Metropolitan Life Insurance Company 1997].

Table 4
Annual cost to employers due to caregiving workers, United States, 1996

	US $
Replacement costs for caregiving employees who quit	4,933,816,305
Costs due to absenteeism	397,596,918
Costs due to partial absenteeism	488,298,715
Costs due to work day interruptions	3,765,122,333
Costs due to elder care crises	1,084,355,232
Costs associated with supervising caregiving workers	805,133,760
Total cost to business	11,474,323,263

Source: Metropolitan Life Insurance Company 1997.

Additional costs may arise due to stress-related conditions experienced by many caregivers. Statistics Canada estimates that stress-related disorders due to overwork cost Canadian businesses $12 billion a year [Lockhead 1998].

Impact on employers

The Conference Board of Canada has drawn up a list of potential problems related to long-term elder care responsibilities. They are: absenteeism, tardiness, frequent interruptions from work for telephone calls, lack of availability for overtime and business trips, inability to accept projects or added responsibilities, requests for a reduction of work hours, health problems, stress, depression, tension, sleep disorders, redistribution of work hours, higher frequency of unpaid leave, reduced quality and quantity of work, greater number of accidents, staff turnover, increased costs and decreased productivity [McBride-King 1999]. Absenteeism due to conflict between work and family responsibilities costs Canadian employers an estimated $2.7 billion in lost time.

Family-friendly policies and culture are thought to have positive impacts on productivity; employee performance and promotability; recruitment, retention and training costs; quality and diversity in the workplace; employee morale, loyalty and job satisfaction; and enhancement of corporate reputation.

A survey of work and family benefit plans for salaried employees of 1,050 major US employers (Fortune 100 and 500 companies) by Hewett Associates found that in 1996, nearly one-third of the employers offered elder care programs, an increase of 17 percent since 1991 [Hewitt Associates 1996]. The most common approach to elder care assistance was resources and referral programs, offered by 79 percent of the employers with elder care programs. Long-term care insurance was offered by 25 percent, up 25 percent since 1991.

Some employers are offering innovative programs. For example, the Elder Care Pager Program of the First Interstate Bank provides a pager, at no cost, to caregiving employees for as long as necessary. The American Business Collaboration for Quality

Dependent Care (ABC), a national coalition led by 22 member companies, is helping to create a national model for escorted transportation for the elderly dependents of employees. Once the program is established in a community, elderly dependents of employees of ABC companies can call on transportation providers whenever they require transportation, for a nominal fee [Brink 2000].

Impacts on health policy

There are two types of impacts on health policy. First, the health system benefits from informal care by not expending health dollars. The amount that informal care saves is under debate, since not all informal care would be replaced by health care. Secondly, caregivers may use the health system more because of health problems related to their caregiving.

In Canada, informal care is still the main source of assistance to seniors. Public home care expenditures have more than doubled in the last seven years and account for a small but increasing percentage of total public health spending, rising from 1.2 percent in 1981 to 4 percent in 1998.

In the United States, a recent study estimated the national economic value of informal caregiving in 1997 to be $196 billion, which is equivalent to about 19 percent of total national health care spending ($1.1 trillion in 1997). This amount dwarfs spending on home care (US $30 billion) and nursing home care (US $79 billion) [Arno and Levine 1999]. In another study, almost three-quarters of the caregivers surveyed said that caregiving had an impact on their health, with more than two in ten reporting significant health problems [Metropolitan Life Insurance Company 1997].

Conclusion

Informal elder care lies at the nexus of family, work and health policy and cannot be studied in isolation. Due to the growth in demand and the decline in potential caregivers and the hours they have available to provide such care, growth in private and public sector care is inevitable. Rather than shifting costs, the costs of elder care must be allocated fairly among public, private and personal purses. Informal care cannot be assumed to be a “free good” without consequences to the economy and society.

Policy analyses across the lifespan and across policy sectors (economic, social, health) are complex because there can be two kinds of impacts: First, one group in the population can benefit at cost to others; and second, one policy sector may benefit while others are negatively affected. Thus, informal care policies may benefit the elderly but may impact workers and their families negatively. Furthermore, while health outcomes may be positive, economic and social effects may be detrimental for one or more groups in the population.

The impacts of such a narrow view of elder care could be long term, intergenerational and society wide. A systemic view of elder care, on the other hand, can result in benefits that are more equitable and effective. Aging is a universal life experience that Canadians should view with optimism.

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