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Assessing Cash-for-Care Benefits to Support Aging at Home in Canada

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FACES OF AGING

ABOUT THIS STUDY

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CONTENTS

SUMMARY

Canada's long-term care (LTC) system needs an overhaul. Most older Canadians have only limited access to care that is often of poor quality and fragmented. There are long wait times for admission to LTC institutions, and many who receive care at home report having unmet needs. As a result, family and friends often have to fill the gaps, and many wear themselves out trying to balance caregiving tasks with work and other family responsibilities. The COVID-19 pandemic has laid bare these long-standing flaws in the system, flaws that risk being exacerbated as the number of the frail elderly grows in the coming years.

In this study, a group of leading scholars led by Colleen Flood argue that the challenge facing Canada's policy-makers is to not only adequately meet the growing needs for LTC services, but also to ensure that those services are delivered where people want to receive them, most often at home. Of course, governments have to improve the quality and safety of care in LTC homes for those who require institutional care. But to avoid unnecessary or unwanted admissions to those institutions, they must also increase funding for formal home care and improve supports for informal caregivers.

The authors investigate a funding solution that is internationally popular: cash-for-care benefits, which are direct public transfers paid to LTC recipients (or their caregivers) to support care at home, whether it is provided by health care workers or by family and friends. Just over half of all OECD countries offer cash benefits to LTC recipients. These benefits give them more control over how their care is organized and provided, and hence more autonomy.

Looking at the experiences of Germany and the Netherlands where cash benefit programs are widely used, Flood and her co-authors find that these benefits are an important part of integrated public insurance plans covering the full range of LTC services. Cash benefits uptake is high in both countries, but it is greater in Germany, where their use is less regulated. Soon after these benefits were introduced, public spending on LTC surged in both countries. In recent years, the Netherlands has put in place a series of measures to curb growing program costs, as well as to address other issues such as concerns about the quality of care provided due to recipients' tendency to rely on untrained caregivers to provide services that should be the domain of health professionals.

The authors conclude that cash benefits hold promise as part of the solution for enhancing supports for home care in Canada. But they are not sufficient on their own: they must be part of a suite of initiatives that includes investing in the quality and safety of care in LTC institutions, improving access to formal home care, and better supporting informal home care. Policy-makers need to proceed with caution, however, and find the sweet spot for cash-for-care benefits. The objective should be to help maximize care recipients' autonomy, address unmet LTC needs, and improve care quality, while minimizing the potential disadvantages for informal caregivers. As the authors point out, these caregivers are mostly women, and a much greater proportion of women

work full-time in Canada than in Germany and the Netherlands. This calls for additional measures to be put in place in Canada to help mitigate the impact on women's longer-term financial security, should cash benefits encourage them to take on more caregiving duties and reduce their participation in the labour market. Examples of such measures are strengthening job-protected leave legislation and supplementing Canada Pension Plan contributions for caregivers.

Demographic pressures loom, and they risk exacerbating the long-standing failures in Canada's LTC systems. Provincial and territorial governments must move quickly to enhance the full spectrum of long-term care services and provide better support to Canadians who wish to age at home.

RÉSUMÉ

Le système canadien des soins de longue durée (SLD) a besoin d'une refonte en profondeur. La plupart des aînés n'ont qu'un accès limité à des soins trop souvent fragmentés et de faible qualité. L'admission en établissement de SLD est sujette à de longues périodes d'attente, et nombre d'aînés recevant des soins à domicile disent avoir des besoins qui ne sont pas comblés. Si bien que leurs proches et amis doivent souvent prendre la relève, alors que plusieurs d'entre eux s'épuisent en tentant de concilier leurs tâches de soignant, leur emploi et leurs autres responsabilités familiales. La pandémie de COVID-19 a exposé au grand jour ces failles dans le système qui existent depuis longtemps et qui risquent de s'aggraver à mesure qu'augmentera le nombre d'aînés fragiles.

Les éminents chercheurs qui ont mené cette étude sous la direction de Colleen Flood soutiennent que les décideurs canadiens doivent relever un double défi : répondre à la demande croissante de services de SLD, mais aussi s'assurer que ces services soient fournis où leurs bénéficiaires désirent les recevoir, soit le plus souvent à domicile. Pour les aînés qui nécessitent des services institutionnels, les gouvernements doivent évidemment améliorer la qualité et la sécurité des soins dans les établissements de SLD. Mais pour y éviter les admissions inutiles ou non désirées, ils doivent aussi mieux financer les soins formels à domicile et renforcer le soutien aux aidants naturels.

Les auteurs ont étudié une solution de financement très prisée à l'étranger : les prestations en espèces. Ces transferts publics sont directement versés aux bénéficiaires de SLD (ou à leurs soignants) en appui aux soins à domicile, qu'ils soient prodigués par des travailleurs de la santé, des membres de la famille ou des amis. Un peu plus de la moitié des pays de l'OCDE offrent ce type de prestations aux bénéficiaires de SLD, qui peuvent ainsi mieux planifier leurs soins et gagner en autonomie.

À l'examen de la situation en Allemagne et aux Pays-Bas, deux pays qui misent largement sur les prestations en espèces, Colleen Flood et ses coauteurs montrent qu'elles sont un élément clé de régimes intégrés d'assurance publique couvrant l'ensemble des services de SLD. Le recours à ces bénéfices est très étendu, surtout en Allemagne,

où leur utilisation est moins réglementée. Peu après leur instauration, les dépenses publiques en SLD ont bondi dans les deux pays, mais les Pays-Bas ont adopté ces dernières années un train de mesures pour freiner la progression des coûts et assurer une meilleure qualité de soins, étant donné la propension des bénéficiaires à recourir à des soignants sans formation pour des services qui devraient relever de professionnels de la santé.

Les auteurs en concluent que les prestations en espèces constituent une piste prometteuse pour améliorer les soins à domicile au Canada. Mais elles ne suffiraient pas à la tâche et devraient donc s'intégrer à une série d'initiatives visant à investir dans la qualité et la sécurité des soins dans les établissements de SLD, de même qu'à améliorer l'accès aux soins formels à domicile et le soutien aux soins informels. Pour optimiser leur utilisation, nos décideurs doivent agir avec discernement en se donnant pour priorité d'accroître l'autonomie des bénéficiaires, de répondre aux besoins en SLD non comblés et d'améliorer la qualité des soins, tout en minimisant les inconvénients auxquels s'exposent les aidants naturels, majoritairement des femmes. Comme les femmes qui travaillent à temps plein sont proportionnellement beaucoup plus nombreuses au Canada qu'en Allemagne et aux Pays-Bas, les auteurs recommandent aux gouvernements de prévoir des mesures supplémentaires pour atténuer l'impact sur la sécurité financière des proches aidants, dans le cas où les prestations en espèces les encourageraient à accroître leurs tâches d'aidantes et à réduire leur participation au marché du travail. On pourrait à cette fin assouplir les lois sur les congés avec protection d'emploi et hausser les contributions du Régime de pension du Canada pour les proches aidants.

Les pressions démographiques qui s'annoncent risquent d'aggraver les insuffisances de longue date de notre système de soins de longue durée. Ottawa et les provinces doivent agir rapidement pour améliorer l'ensemble des services de SLD et offrir un meilleur soutien aux Canadiens qui souhaitent vieillir à domicile.

THE MANY PARTS OF A BROKEN SYSTEM

As we write (in March 2021), Canada is in the midst of the COVID-19 pandemic, which has exposed deep problems of quality, safety and overcrowding in long-term care (LTC) homes. This has prompted calls for stronger regulatory oversight of LTC homes to ensure adequate staffing and training levels; proper safety protocols; and regular, rigorous inspections (Estabrooks, Flood and Straus 2020; Picard 2021). Multiple reports of neglect, suffering and pandemic-related deaths in LTC homes over the past year have likely reinforced many Canadians' desire to age in their homes as long as possible. In response, provincial and territorial policy-makers should not only improve the quality of care in LTC homes, but also move away from a heavy reliance on institutional care by expanding options for LTC care services delivered at home.

Many of the LTC needs of older Canadians could be met in their homes. This includes help with feeding, dressing and continence, as well as shopping, food preparation, housekeeping and transportation. Help can be provided by formal caregivers, such as nurses, therapists and personal support workers, or by unpaid informal caregivers, such as family members and friends.

Among Canadians who need LTC services at home, many report having major unmet needs and little control over how their care is organized and provided. According to the 2015/2016 Canadian Community Health Survey, over 430,000 adults said that their home care needs were unmet to at least some degree, mostly due to a lack of available services. Those receiving publicly funded home care complain that there is not enough continuity of care, as they often have to interact with different caregivers. Plus, support for certain activities of daily living, such as help with food preparation and errands, does not qualify for public funding. As a result, informal caregivers are left to fill the gaps, and they are increasingly susceptible to burnout. In 2016, 44 percent of people in Ontario who received home care from an informal caregiver (for some or all of their needs) reported that their helper experienced distress from the challenges of their role, a 21 percent increase from 2014 (Ontario 2019).

According to the Canadian Institute for Health Information (CIHI), the range of problems that plague the home care system — including financial constraints, limited availability of services, confusion on how to access services and lack of responsiveness — prompt older Canadians to default into institutional care. Between 2012-13 and 2014-15, about 1 in 5 seniors who entered LTC institutions had care needs that likely could have been met with home care (CIHI 2017). Approximately 80 percent of all LTC spending in Canada goes to institutions, with the remaining 20 percent spent on home care. This does not account for the additional unpaid LTC provided by family caregivers (Grignon and Spencer 2018). By directing such a small percentage of public funds to home care, Canadian provinces and territories are arguably encouraging many to opt for institutional care, when they would rather receive care in their homes (Grignon and Pollex 2020).

Ideally, only those with the highest care needs should be cared for in an institution. Yet for many Canadians with low to modest care needs, the current obstacles to organizing

and financing care at home are too great to manage. Over the next 20 years, the number of older adults is expected to rise considerably, increasing overall LTC needs. How can Canada ensure that, as its society ages, the growing needs for LTC are not just met, but also that those services are delivered where people want to receive them?

In light of the systemic failures in LTC that the pandemic exposed, consensus is growing that provincial and territorial governments, with the support of the federal government, must invest more in all forms of LTC services. They must not only improve the quality of care in LTC homes for those whose needs are best met in institutions. They must also increase funding for formal home care provided by health care workers and increase supports for informal caregivers.

This study explores whether providing cash benefits to LTC recipients, in addition to expanding formal home care services, could achieve the right mix of LTC supports at home. The recipients would use the cash benefits at their discretion to compensate family and friends providing informal care, to purchase formal home care services or additional support for activities of daily living, or to pay for equipment and home renovations that facilitate their aging at home. Such benefits play a significant role in LTC systems in many other OECD countries. We investigate the experiences of Germany and the Netherlands with LTC cash benefits, and consider their transferability to Canadian provinces and territories.

We conclude that although there are considerable advantages to cash benefits, policy-makers should proceed cautiously. One risk is that working-age women could be encouraged to take on too many caregiving duties at the cost of their long-term financial or employment prospects. And without careful regulations to restrict their use, cash benefits could increase LTC costs, reduce the quality of care and further expose migrant LTC workers to potentially exploitative work environments. To mitigate these risks, policy-makers should target cash benefits to those with low to moderate care needs, and ensure that informal caregivers are not penalized financially over the long term for taking time off work to care for a family member.

THE CHALLENGE: HIGHER NEEDS AND POOR ACCESS TO QUALITY LONG-TERM CARE

Canada's population is aging and LTC needs are growing. Based on the 2016 Census, the proportion of Canadians aged 65 and older has never been greater, and it will continue to grow in coming years (Statistics Canada 2017).[1] The largest increase is among those over the age of 84, of whom 65 percent are women (Statistics Canada 2019a). An aging population reflects advances in public health and medicine. But it also implies growing LTC needs, because older adults are more likely to have health problems: in Canada, 47.4 percent

[1] In 2016, 16.9 percent of the population was aged 65 and older (5,935,630 people out of a total of 35,151,728). According to population estimates, in 2019 approximately 17.5 percent of the population was aged 65 and over (6,592,611 people out of a total of 37,589,262). Population estimates on July 1, by age and sex (Statistics Canada 2019b).

of those aged 75 and older report either a physical or a cognitive disability (Morris et al. 2018). These trends are occurring in a context where there are long wait times for admission to LTC homes and significant unmet needs in the community. For example, as of February 2019, in Ontario the average wait for placement in public LTC homes was 161 days, with 34,834 people registered on waiting lists (Ontario 2019). This demand is partly driven by the lack of publicly funded care to support aging in place (Ontario 2015).

Public spending on LTC varies significantly across OECD countries. In 2017, the OECD average was 1.7 percent of GDP. Spending ranged from 3.7 percent in the Netherlands, to 0.2 percent in Hungary and Estonia, with Canada at 1.3 percent. Canada is one of the few OECD countries that does not allocate public funds to LTC supports for common household tasks that enable a person to live independently, such as shopping, laundry, cooking and housework (OECD 2020). Several experts have argued that new investments are needed, and that they should mainly go to expanding and broadening home care services (Quebec 2013; Ontario 2015).[2]

In addition to concerns about access to and the quality of LTC services in Canada, the costs of these services, both private and public, will grow significantly in the coming decades. MacDonald, Wolfson and Hirdes have projected that, between 2019 and 2050, "the cost of public care in nursing homes and private homes will more than triple, growing from $22 to $71 billion annually (in 2019 dollars)…by 2050, there will be approximately 120 percent more older adults using home care support" (2019, 7).[3] This projection likely underestimates the growing costs of LTC, because it excludes the additional funding required to improve care quality, which Canadians recognize as urgent in the wake of the COVID-19 pandemic.[4]

Perhaps it is assumed that future LTC needs can be met informally by family members and friends, but this runs counter to demographic trends: "by 2050…there will be approximately 30 percent fewer close family members – namely, spouses and adult children – who would potentially be available to provide unpaid care" (MacDonald, Wolfson and Hirdes 2019, 7). Further, more people are living alone than ever before. The 2016 Census showed that one-person households, at 28 percent of all households in Canada, surpassed those consisting of couples with children. Because older adults today have fewer children than earlier generations, the average unpaid caregiver will need to increase their efforts by an average of 40 percent to keep up with LTC care needs (MacDonald, Wolfson and Hirdes 2019).

There is also a significant gender dimension to LTC and the aging population. As personal support workers, women disproportionately provide formal home care and care services in long-term institutions. Women have also traditionally taken responsibility

[2] Some have said that the problems exposed in LTC homes by COVID-19 underscore the extent to which Canada needs to encourage a shift from institutional care to home care (see Paikin 2020), both formal and informal.

[3] Of course, these costs could fall to "future generations of taxpayers with many more elderly dependents to support than is the case today" (Busby and Blomqvist 2016, 9-10).

[4] For instance, relatively low rates of pay must be increased, because recruitment and retention in the LTC workforce are a constant struggle (Colombo et al. 2011).

for informal caregiving (Colombo et al. 2011). This pattern is compounded by common age differences in heterosexual couples, which mean that women often end up caring for their older male partners, but do not necessarily have anyone to care for them when they outlive their spouse. Although the gender gap in life expectancy is slowly closing (Gaymu et al. 2010), Canadian women live on average 84 years and men 79.9 (Statistics Canada 2019a). The bottom line is that fewer family caregivers will be available to provide care for the rapidly growing group of elderly Canadians.

Are cash benefits a solution?

One internationally popular funding solution is cash benefits: direct public transfers to LTC recipients (or their caregivers) to support care at home, be it formal care by professional providers or informal care by family and friends. Just under half of all OECD countries offer cash benefits to caregivers, and slightly over half offer cash benefits to care recipients. Only five OECD countries offer neither (Colombo et al. 2011).

Several Canadian provinces have "self-managed home care" programs, which give a limited number of applicants the option of self-directing the commissioning of their care, but payment of family members is generally discouraged (British Columbia Law Institute and Canadian Centre for Elder Law 2010). A "direct allowance" in Quebec allows recipients to choose their home care service provider instead of receiving services provided by regional health institutions. Funds can be used to purchase services from third-party providers, but not from family members.[5] In 2017-18, this program served 11,000 recipients and accounted for 18 percent of public home care hours delivered to older adults.

Only Nova Scotia currently provides cash benefits to family members supporting people with LTC needs. The Nova Scotia Caregiver Benefit program supports the provision of care to low-income individuals who are highly disabled by paying a nontaxable cash benefit of $400 per month directly to caregivers who provide 20 or more hours of unpaid care (Nova Scotia 2016). Despite earlier research examining the potential merits of cash benefits to compensate family caregivers, this approach has not been adopted elsewhere in Canada (Keefe and Rajnovich 2007; Keefe, Glendinning and Fancey 2008; Keefe 2011).

CASH BENEFITS PROGRAMS IN THE NETHERLANDS AND GERMANY

Cash benefits programs offer important advantages. First, and most importantly, cash benefits can increase care recipients' and their families' autonomy by giving them choice in organizing their care services, and allowing family members to take time away from work to provide care (Da Roit and Le Bihan 2010). Second, cash benefits could reduce costs if they enable low-cost substitution between different types of LTC services. For example, home care may be a substitute for admission to publicly funded

[5] These financial supports are referred to as a "direct allowance – service employment paycheque." This allowance is allocated to care recipients by the health and social services centre that assessed their needs and established an intervention plan indicating the number of hours of home care to which they are entitled. Care recipients can choose the person who will provide that home care (Quebec 2019).

LTC facilities, and informal care may be a substitute for formal care. Third, cash benefits could reduce inequities by distributing the cost of LTC more broadly across society, rather than imposing much of it on informal caregivers.

The experiences of Germany and the Netherlands provide useful case studies. In both countries, cash benefits schemes are integrated into public health insurance plans that offer a mix of institutional care, as well as formal and informal health care services.[6] However, the design of cash benefits programs and their uptake differ notably in the two countries. The program is more strictly regulated in the Netherlands, and the uptake is much lower (Bakx et al. 2015). And although both countries have universal LTC insurance plans, Germany spends considerably less on LTC insurance as a percentage of GDP.

The Netherlands

The Netherlands was the first OECD country to establish a universal, mandatory LTC insurance (LTCI) plan, in 1968. The program was financed in a way that is similar to its national social health insurance (SHI). Under SHI, workers and their employers contribute a premium (set as a percentage of their income) into a collective insurance fund that provides universal coverage for health care services.[7] The Dutch LTCI plan initially covered only institutional care, but over time the benefit package expanded to include, for example, home health care and outpatient mental health care. However, the plan became increasingly expensive and was criticized for its paternalism, the inflexibility of care options and professionals' excessive authority in determining the care that people received.

Beginning in the 1990s, LTC recipients in the Netherlands sought reforms to gain more freedom and autonomy (Kremer 2006), which led to the implementation of the cash benefits budget (the *Persoonsgebonden*, PGB). The PGB was introduced as an experiment in 1995 and was officially adopted in 2001. In 2015, additional reforms established cash benefits under three funding sources: (1) social health insurers, for home health care, such as community nursing, under the *Health Insurance Act* (as a substitute for community nursing contracted by health insurers); (2) municipalities, for social care and assistance (e.g., housekeeping) under the *Social Support Act*; and (3) the state, for intensive (i.e., around-the-clock) home care (as a substitute for institutional care under the public LTCI scheme). Cash benefits account for 10 percent, 11 percent and 8 percent respectively of LTC expenditures via these three sources of financing (The Netherlands 2017).

[6] Both countries have national LTC insurance plans, in which individuals make income-adjusted payroll contributions during their working lives in order to access benefits if they have a disability later in life (people pay in proportion to income, but the risks are pooled so that people draw out of the funds according to their LTC needs, if any). In contrast, the *Canada Health Act* does not specify LTC as a "medically necessary" service in the same way it does hospitals and doctors, hence provincial coverage varies greatly. Some provinces impose, for example, means-tested copayments.

[7] Unlike general tax revenues, which can be allocated to other expenditure needs, SHI premiums are earmarked for health care purposes and, importantly, are administered at arm's length from the government.

How are cash benefits regulated in the Netherlands?

The Independent Care Assessment centre evaluates individuals' care needs using a national standardized assessment form. For the elderly, there are 10 "care-severity packages," ranging from moderate to high needs (Bakx, Douven and Schut 2016). The centre determines whether clients are eligible for institutional care or intensive home care, as well as the number of hours of care needed. Eligible recipients can choose either formal services, corresponding to the assessed number of hours of care needed, or a cash benefit that is equivalent to up to 100 percent of the cost of formal care (table 1).

Table 1. Cash benefits as a substitute for institutional care, by care level, the Netherlands, 2017 (euros)

Care level grade[1]	Cash benefits per month
1	1,243
2	1,802
3	2,194
4	2,940
5	3,989
6	3,989
7	4,997
8	5,964

Source: Zorginstituut Nederland (2017), "Tarieventabel 2017. Persoonsgebonden budget Wlz (ZZP of zorgprofiel)," https://adlonzorg.nl/docs/Tarieventabel-pgb-Wlz-2017-met-verblijf-lang.pdf.

[1] As of 2013, the first three care level grades no longer entitle people to institutional care (and the related cash benefits); however, those graded in one of these levels before 2013 retain their entitlements.

Cash benefits that substitute for institutional care are granted as "drawing rights" from the Social Insurance Bank (SVB), which establishes and controls a personal health budget for each eligible citizen. Cash benefits can be invoiced to individuals' personal budget, up to an annual maximum, to pay caregivers based on formal contracts arranged between users and caregivers. Various standardized contract forms are available online for formal and informal care.

Before 2015, the cash benefits option in LTCI applied to institutional care as well as broader home care needs. The cash benefits option proved so attractive that it led to a rapid increase in uptake and government costs (Gaymu et al. 2010). A 2012 government proposal to reduce spending on cash benefits by restricting access to those who were eligible for institutional care failed. In 2015, however, new measures were introduced to curb spending (Rothgang et al. 2016). Entitlements to cash benefits for home health care and social care have been further restricted by requiring patients to demonstrate the need for specific care that cannot be delivered by formal providers contracted by health insurers or municipalities.

Health insurers and municipalities determine the maximum amount of cash benefit that can be paid to informal caregivers. Typically, that amount is set at 60 percent to 75 percent of the maximum fee paid to formal caregivers for equivalent services. The use of cash benefits is strictly controlled: the Social Insurance Bank pays the benefits directly to the caregivers, based on contracts established between caregivers and care recipients, even if the person providing care is a relative. For home health care covered by the Dutch version of medicare, recipients must justify and account for all payments to informal caregivers with their health insurers.

Over time, the Dutch government has taken several measures to prevent or combat fraud, such as (1) introducing cash benefits in the form of drawing rights, in which the individual invoices a personal health budget, rather than receiving money directly; (2) introducing home visits to verify whether and how the care is provided; (3) introducing "informed choice" conversations with applicants to ensure that the arrangements meet their needs and preferences; and (4) adding qualification criteria that make it more difficult to access cash benefits. In 2018, the government launched the Legitimate Care Program, which introduced additional measures to counteract fraud in health care, including in the cash benefits scheme (The Netherlands 2018).

A 2018 study found that the Dutch cash benefits program was of the greatest benefit to chronically ill individuals with complex care needs (van de Camp et al. 2018). Recipients of cash benefits assess the program more positively than do formal care providers and health insurers (van de Camp et al. 2018). Insurers point out that, when cash benefits recipients arrange care for themselves, the care may not be of high quality (van de Camp et al. 2018). The most common perceived advantage of cash benefits is the freedom of choice to control and organize the care received (Ramakers, van Doorn and Schellingerhout 2011; van de Camp et al. 2018). The most common perceived disadvantage of cash benefits is the administrative burden it imposes on the care recipient and their family (Ramakers, van Doorn and Schellingerhout 2011).

Germany

While cash benefits were an add-on to the Netherlands' existing LTCI plan, Germany's cash benefits program was central to its LTCI plan when it was launched in 1995. Before the early 1990s, LTC in Germany was mainly provided informally by families; when required, professional services were provided for the most part by charitable organizations and paid for out of pocket by recipients or through social assistance. This reflected Germany's strong tradition of voluntarism and family support (Rothgang and Götze 2014). Several factors spurred LTC reform in 1994. Because people of modest means had to pay the full cost of institutional care, many ran down their savings: approximately 80 percent of those in LTC institutions depended on social assistance (Rothgang et al. 2016). Municipalities and federal states complained as social assistance costs surged (Da Roit & Le Bihan, 2010; Geraedts, Heller and Harrington 2000). In addition, concerns grew about the care burden on families – especially on women as informal caregivers – and the lack of available caregivers as female employment rates were rising (Rothgang and Götze 2014).

The inclusion of cash benefits in Germany's new universal LTCI plan in 1995 had three goals. First, to make the system more flexible and responsive to needs: cash benefits would give recipients more control over their care and could increase competition among formal care providers. Second, by setting the payments lower than the cost of equivalent care provided by formal LTC caregivers, cash benefits were expected to reduce government costs. Third, policy-makers hoped the benefits would encourage and validate the importance of informal caregiving.

How are cash benefits regulated in Germany?

The Medical Review Board conducts LTC needs assessments using an evaluation tool to determine individuals' physical and cognitive disability levels (Rothgang et al. 2016; Bäcker 2016). As in the Netherlands, benefits vary according to assessed need, and benefit amounts are adjusted as recipients' needs change over time. Those who qualify for LTC may choose between formal care services, cash benefits or a combination of both. The German LTCI plan has expanded from three to five care-level grades, with cash benefits set at 50 percent of the cost of equivalent formal care services (table 2).

Table 2. Cash and in-kind benefits for home care, by care level, Germany, 2017 (euros)

Care level grade	Value of formal care per month	Cash benefits per month
1	125	0
2	689	316
3	1,298	545
4	1,612	728
5	1,995	901

Source: Bundesministerium für Gesundheit, "Pflegeleistungen zum Nachschlagen," 2021, Berlin, page 38, https://www.bundesgesundheitsministerium.de/fileadmin/Dateien/5_Publikationen/Pflege/Broschueren/BMG_Broschuere_Pflegeleistungen_Nachschlagen_bf.pdf.

One priority of the German cash benefits program is to enable care recipients and their families to choose the most appropriate care arrangement for their needs, preferably at the individual's home (Da Roit and Le Bihan 2010). Thus, there is no regulatory oversight of how the care recipients spend the cash, which allows them to access a broader range of services than those offered by formal home care services. However, for those belonging to care grades 2 (moderate needs) through 5 (high needs), the law requires a routine consultation with professional service providers.[8] For care grades 2 and 3, this consultation takes place every six months; for grades 4 and 5, consultations are quarterly. During visits, service providers can make nonbinding recommendations to beneficiaries and their caregivers regarding the use of professional services.

A care recipient's income has no bearing on their LTC eligibility or on the amount of the cash benefit they are entitled to. A majority (51.7 percent) of beneficiaries opt for cash benefits (Rothgang and Müller 2019, 12). Germany's high proportion of cash benefit recipients, compared with the Netherlands, is likely due to the fact there are fewer restrictions on the use of cash benefits. In 2017, spending on cash benefits accounted for 26 percent (or €10 billion out of €38.5 billion) of total spending for social LTCI.

[8] See section 37, paragraph 3, SGB XI of the Social Code Book XI, Germany, 1994.

IMPLEMENTING A CASH-BENEFITS PROGRAM IN CANADA: POLICY CONSIDERATIONS

Cash benefits are very popular in Germany and the Netherlands. A comparison of the experiences in the two countries reveals that imposing fewer limitations on how the benefits are spent provides recipients and their families with greater autonomy, flexibility and choice in organizing a care bundle suited to their own needs and capacities. On the other hand, such flexibility results in higher uptake and thus greater public spending and may not improve care quality. Indeed, due to budget constraints and concerns over quality of care, the Netherlands has recently become more aggressive than Germany in restricting the access to and use of cash benefits.

Cash benefits are an appealing option for Canadian provincial and territorial policy-makers looking to address the shortcomings of LTC services received at home that can prompt premature admissions into LTC institutions. On the one hand, cash benefits could address unmet care needs due to the limited availability of formal home care services, provide support for unattended activities of daily living, and give recipients (and by extension their informal caregivers) greater choice in the mix of services that they receive. On the other hand, the Dutch and German experiences highlight implementation problems that the provinces and territories must consider; in particular, the consequences for working-age women, the resulting costs for government, the unintended effects on migrant workers and concerns regarding quality of care.

Gender considerations and women's participation in the labour force

There are important gender considerations in LTC generally and in implementing cash benefits schemes specifically. Women make up a majority of the frail elderly population and the LTC workforce, both in institutions and among formal and informal home caregivers (Estabrooks et al. 2020). For women who are already providing informal home care, compensation via cash payments could help validate their work and better enable them to organize respite care and other supports. However, if cash payments were to encourage more working-age women to provide more informal care, this could reduce their participation in formal employment and, in the longer run, reduce their lifetime income-earning potential.

In Canada, women account for 54 percent of all informal caregivers for older adults and are more likely than men to spend 20 or more hours per week on caregiving tasks (Sinha 2012). Notably, types of care work are divided along gender lines: women generally tend to activities that must be done on a regular or set schedule (e.g., travelling to medical appointments, preparing meals), whereas men take on tasks that can be completed in short, flexible bursts of time (e.g., yard work) that do not disrupt their paid employment (Sinha 2012). According to the most recent estimates for Canada, the wages forgone by caregivers between 2003 and 2008 due to missing work, reducing work hours or leaving paid employment entirely stood at $221 million annually for women, compared with $116 million for men (Fast 2015). Therefore, to the extent that cash benefits programs increase the numbers of people who give up paid

employment to provide informal care, the question is whether such a measure would further disproportionately burden women, or would it encourage more men to provide informal care services (Keefe and Rajnovich 2007)?

Labour markets in Canada differ markedly from those in the Netherlands and Germany. Although the overall proportion of women aged 15 to 64 in the labour force is similar across the three countries, the percentages of women who work full-time are notably different: 74.2 percent in Canada in 2018, compared with 63.4 percent in Germany and 42.0 percent in the Netherlands (table 3).[9] In view of the Dutch and German experiences, policy-makers have to consider the consequences should a cash benefits scheme prompt more Canadian women who are working full-time to increase the time they spend providing LTC to a family member.[10]

Table 3. Labour force participation and full-time and part-time employment rates among women in Canada, Germany and the Netherlands, 2018 (percent)

	Labour force participation[1]		Women's employment[2]		
	Women	Men	Part-time	Full-time	Share of part-time employment
Canada	75.1	81.7	25.8	74.2	65.7
Germany	74.3	82.9	36.6	63.4	77.4
The Netherlands	75.8	84.7	58.0	42.0	72.5

Source: OECD (2020).
[1] Women and men aged 15-64.
[2] Women aged 15 and over.

One unresolved issue is this: are women more likely to provide informal care because they have lower incomes than men, or do women have lower incomes *because* they provide informal care? Some researchers have found that, for women, having a lower salary increases the likelihood they will provide informal care (Carmichael et al. 2005). And women who have a high income are less likely to leave the labour force to provide informal care (Schneider, Drobnic and Blossfeld 2001). Other research shows a correlation between providing informal care and reduced hours of work, which in turn leads to a decrease in salary among women, whereas no such effect was found among men (Kotsadam 2012).

[9] The low Dutch numbers could be partly because working full-time is reportedly not a financial necessity, given Dutch wage levels (Bosch, van Ours and van der Klaauw 2009). Furthermore, the Dutch social security system is structured to support participation by part-time workers, who contribute and draw benefits on a pro-rated basis. This policy dates to the 1990s, when the Netherlands moved away from a "male breadwinner" model to its current vision of "1.5 workers per household."

[10] Indeed, such considerations contributed in part to the Japanese Ministry of Health and Welfare's decision to reject cash benefits – after it looked at the German example – when it reformed its own LTC system, fearing that they would cause "the existing pattern of family care-giving [to] become frozen in some cases, with the danger that women [would] be tied down by family care-giving" (Campbell, Ikegami and Kwon 2009, 72). It is important to note that the advocacy of women's groups also played a role in the Japanese Ministry of Health and Welfare's decision to reject cash benefits. These groups argued that, despite cash benefits increasing household incomes, these benefits would not lessen the burden of informal caregiving (Campbell, Ikegami and Gibson 2010, 90; Campbell 1997, 3; for a general discussion, see Peng 2002).

The effects on women of introducing a cash benefits program must also be considered in the broader context of whether additional social supports are in place to mitigate the strains and financial costs borne by informal caregivers. Such supports include care leave, flexible work schedules, social security benefits, respite care and daycare programs, and career training. In Germany, cash benefits are one of many mechanisms that support and recognize informal caregivers' contributions. For example, if a family member in Germany provides at least 14 hours of care weekly (and is employed up to only 30 hours per week), the LTCI plan covers the caregiver's social security contributions and provides respite care for a vacation. In addition, the *Care Leave Act* (*Pflegezeitgesetz*) of 2015 extends unpaid leave to up to 24 months, providing family caregivers with job security upon re-entry into the workforce. And caregivers may apply directly for an interest-free government loan that covers half of their forgone net earnings due to reduced working hours (Schneekloth et al. 2017).

In the Netherlands, in addition to being eligible for a paid leave (at 70 percent of earnings) of up to 10 days to care for family members in cases of urgent need, employees may take a prolonged unpaid leave, up to a maximum of 6 weeks (or 6 times the number of hours worked per week during the preceding 12-month period). Further, flexible work hours are set in legislation, and, depending on the sector and employer, these can be used to facilitate informal caregiving (Colombo et al. 2011). In the Dutch context, there is no evidence that informal caregiving diminishes women's participation in the labour force.

Using data from 1999 to 2008, a recent study by Rellstab et al. (2018) examines whether the earnings or probability of employment of adult children declines if their parent is unexpectedly hospitalized. This research suggests that the extensive public coverage of LTC services allows Dutch residents to deal with family members' adverse health events without affecting their labour participation.[11] This finding also holds true because a relatively large proportion of Dutch women choose to work part-time, which, in combination with extensive formal LTC care options, may enable them to provide some informal care without reducing their work hours.

Financial support policies that contribute to caregivers' pensions and provide other social security benefits appear to mitigate some of the long-term consequences of care work and its impact on women (Keefe and Rajnovich 2007). Various programs in Canada offer care leave and other indirect benefits to caregivers (e.g., the federal Canada Caregiver Credit). But unlike in Germany, most of these benefits are available only to caregivers who are employed full-time (British Columbia Law Institute and Canadian Centre for Elder Law 2010).

Anticipating demand and costs to governments

Provincial and territorial governments concerned about rising future LTC costs under current demographic projections may be tempted by a cash benefits program as a

[11] The research found no effect on either the probability of employment or conditional earnings for Dutch men and women, whether the analysis is of the full adult population or of subgroups who are more likely to become caregivers. One caveat is that the Rellstab et al. (2018) findings apply to the era when LTC coverage in the Netherlands was more generous.

way to contain spending. This could be the outcome if home care were a substitute for more costly care in institutions or if informal caregiving were a substitute for more costly formal home care services. However, policy-makers hoping to save money with a cash benefits program need to be aware of the "woodwork effect" – whereby people currently not receiving care services "come out of the woodwork" to claim the benefits. This seems to have occurred in both Germany and the Netherlands, where the introduction of cash benefits coincided with increased rather than decreased public LTC spending.

Both Germany and the Netherlands have implemented measures to control the costs of their cash benefits programs. In Germany, the amount offered is significantly lower than the cost of equivalent formal care services. In the Netherlands, the benefit is differentiated so the LTC recipients receive less money if they use it to pay for informal rather than formal caregivers.

It is unclear whether a cash benefits scheme would increase the provision of informal care, as opposed to giving compensation for care that would have been provided regardless. In a study carried out in Germany shortly after LTCI was introduced, participants stated that, if the cash benefits option were not available, they would have continued with their existing informal care arrangements, rather than accepting formal services (Evers 1998). From the Netherlands, too, there is evidence that, after the cash benefits program was introduced, recipients began paying informal caregivers who would have otherwise continued to provide care without payment (Mot 2010). Although recognizing the current work of informal caregivers with cash benefits is a worthy goal, there is insufficient evidence to conclude that cash payments alone would significantly increase the provision of care to meet growing LTC needs.

In the Netherlands, public spending on cash benefits quintupled between 2000 and 2012, threatening the financial sustainability of the Dutch LTCI plan (Mot 2010; Maarse and Jeurissen 2016). When the plan was evaluated in 2007, the assistant secretary noted:

> *At the moment, it seems that the far-too-generous definition of the entitlements in general, in combination with "the convenience of money," is the cause of an unprecedented growth – without there being apparent substitution of care in kind. In itself, growth does not have to be negative. But an extreme growth that cannot be explained easily…demands a very critical look at the instrument – precisely to keep the good elements for the future. [translation from the Dutch]* (Mot 2010)

Partly as a result of the unanticipated uptake and increased expenditures, the Dutch system of cash benefits was overhauled in 2015 to control costs.

If Canadian provinces and territories decide to experiment with cash benefits, they should carefully evaluate whether doing so would expand the provision of home care services. Of course, if the underlying policy objective is not cost savings, but a desire

to recognize the value of informal care and give people more autonomy to age at home, such potential cost increases could be considered appropriate.

A grey market for migrant care workers

In Germany, cash benefits spurred a grey market for caregivers, where families use the money to hire untrained nonfamily members, often migrants, to provide care. Migrant workers can provide 24-hour care that would be either too expensive to purchase if provided by nonmigrant workers, or too impractical and inconvenient for family members to provide directly. There are 100,000 to 200,000 migrant care workers in Germany. They are typically women from Eastern and Central Europe aged 50 to 65, working in conditions that are not controlled by social and labour regulations (Colombo et al. 2011). While data on this grey market are difficult to obtain, various studies involving interviews with caregivers suggest that their work is burdensome and exploitative, with many migrants referring to their jobs as intolerable (Kalwa 2010; Karakayali 2010; Ignatzi 2014; Satola 2015). In the Netherlands, the cash benefits program is designed to discourage care recipients and their families from turning to the grey market. Regulatory constraints on the use of cash benefits and the relatively high availability of formal home care services have led to the development of a highly regulated care market (Da Roit and Le Bihan 2010).

In Canada, some caregivers arrived through the Live-in Caregiver Program (LCP) before the program was ended in 2014 (Canada 2020c). The LCP was designed to address the shortage of caregivers willing to live in their employer's residence (Canada 2017). Although the program was typically used as a means to provide child care to families, an increasing number of live-in-caregivers have been recruited to care for the disabled and frail elderly (Atanackovic and Bourgeault 2013). Live-in caregivers could apply to become permanent residents of Canada after 24 months of full-time, live-in employment or after 3,900 hours of employment within four years of their arrival (Canada 2017). To overcome concerns around abuse and the challenges in becoming a permanent resident at the end of the program, Canada created the Home Support Worker Pilot Program, which removed the live-in requirement. This program allows a limited number of caregivers to come to Canada to provide care and to eventually apply to become permanent residents (Canada 2020d).

This pilot program would likely become more popular if cash benefits for care recipients were introduced across Canada with few regulations to restrict their use; extra attention would have to be paid to these workers' working conditions. Migrant caregivers are particularly vulnerable to exploitation because their chances of remaining in Canada depend on the goodwill of their employers, with whom they are in a particularly intimate relationship. The precariousness of their situations could be partly addressed by better enforcing labour laws, but the process requires the workers to first file a claim or complaint. This is risky for caregivers, because this would likely bring them into direct conflict with their employers.

Quality of care

As cash payments may incentivize an ever-greater reliance on informal care, the quality of care provided by untrained caregivers is a concern. Surveys of users of cash benefits programs indicate that beneficiaries perceive the care they receive from family members to be of better quality than that from strangers (Keefe, Glendinning and Fancey 2008). Similarly, Dutch recipients of cash benefits assess the quality of care more positively than do formal care providers and health insurers (van de Camp et al. 2018). However, users may not be knowledgeable enough to judge the quality of their care or may have strong emotional attachment to their family caregivers, which may bias their assessment. More concerning is the potential for elder abuse under care arrangements financed by a cash benefits scheme. Elder abuse mostly takes place in the community, often at the hands of family members, and often goes unreported (Canada 2015).

How individuals judge the quality of care they receive at home may also be influenced by their views of alternative care options. Only 22.4 percent of Germans believed that "the best option for an elderly father or mother in need is to move to a nursing home" (Alders et al. 2015, 818), while 46.3 percent agreed in the Netherlands. This might reflect the high level of investment in Dutch LTC facilities, making them a more viable and humane choice. It seems likely that, in the Canadian context, the preference for care at home is driven at least in part by the poor reputations of many LTC facilities.[12]

Regular monitoring could help ensure that care recipients' needs are being met, but measuring quality in home care settings is complex, especially since individuals' LTC needs change over time. Moreover, such monitoring may be costly, and quality standards are challenging to enforce when benefits are used to purchase services from family members. Conventional quality-assurance mechanisms, such as professional accreditation, agency regulation and inspection regimes, are currently absent in informal care. Because it could be difficult to discipline (or terminate) poor-performing relatives, monitoring agencies would likely offer more training instead. To further respond to such concerns, a cash benefits plan should distinguish between the home care services that are appropriate for informal caregivers to provide and those that should be contracted out to professionals. Adherence to some minimal standards, such as infection control training, should also be required before cash benefits are paid to informal caregivers (though the amount or types of training and supervision family caregivers receive might still be inadequate for more complex health care needs) (Keefe, Glendinning and Fancey 2008).

FINDING THE SWEET SPOT FOR CASH BENEFITS IN LONG-TERM CARE

Cash benefits are a practical option that many OECD countries use to improve access to LTC services for those with low or moderate care needs and to enable more aging in place. Better access to LTC services at home can also reduce unnecessary and

[12] During the COVID-19 pandemic, damning reports about the quality of care in LTC homes were released by the Canadian military, brought in by the provinces of Quebec and Ontario to help (Canada 2020a; Canada 2020b).

unwanted admissions to LTC institutions and give recipients more say and choice on how their care is organized and provided. Policy-makers need to find the sweet spot to maximize care recipients' autonomy, address unmet LTC needs, ensure and improve quality and safety, and minimize any long-term financial downsides for informal caregivers.

Although cash benefits for home care are touted as a means to reduce government costs, Germany and the Netherlands have learned that such benefits are more likely to increase public spending. The high uptake of cash benefits outweighs any potential substitution toward more cost-effective forms of care. For Canada, increased costs should not prima facie be an impediment, since *more* funding is needed to improve the quality of LTC in facilities and at home. Cash benefits should, therefore, be part of a suite of initiatives that includes more investment in the quality and safety of LTC institutions, better access to formal home care, and greater support for informal home care.

Providing cash benefits should be part of an overall strategy to support LTC needs at home, though they may be less appropriate or effective as older adults age and their care needs increase (British Columbia Law Institute and Canadian Centre for Elder Law 2010). To ensure adequate care, improved access to high-quality formal home care services would nevertheless be required to complement informal care. Hence, new funding must also be directed to *formal* home care tailored to individuals with moderate to high care needs. Although some people with moderate home care needs may wish to receive care only from family members, all should have the option to choose formal care if they want it. Furthermore, formal services may be necessary for those living alone — a fast-growing group of older adults. Policy-makers also need to better evaluate the differences in quality between informal and formal care services; in particular, how to differentiate between the technical quality of tasks completed and the emotional quality that care recipients report.[13]

Cash benefits with few restrictions would have significant uptake, but it is unclear how much more care would be delivered as a result. Cash payments can certainly help achieve the goal of validating and assisting those who are already providing informal care and bearing an inequitable share of LTC costs in Canada. However, serious consideration should be given to the consequences for those, mainly women, who may be drawn away from full-time paid employment to provide home care, which could lower their lifetime incomes.

Because a much greater proportion of Canadian women work full-time than is the case in Germany and the Netherlands, expanding informal care provision through cash payments is arguably more manageable for Dutch and German women. For Canadian women, the consequences of a potentially significant shift from full-time to part-time

[13] There are concerns that the monetary aspect of cash benefits might alter the nature of caring relationships (Keefe and Rajnovich 2007). We must evaluate the quality and safety of care delivered if we move to an ever-greater reliance on care provided by family members: for example, whether the benefits of being cared for by someone with whom one has a strong emotional connection outweigh that carer's lack of formal training. Further research is also needed on how to train family members to provide more complex care at home.

work must be taken into account. To alleviate these concerns, policy-makers looking to implement cash benefits would need to also consider providing additional supports for informal caregivers, such as strengthening job-leave legislation, bolstering respite support and supplementing their Canada Pension Plan contributions.

IMPROVING LONG-TERM CARE TO ENABLE MORE AGING IN PLACE

The COVID-19 pandemic has highlighted the need to reform long-term care policies in Canada to address serious shortcomings in design and delivery. Moreover, our governments are not prepared to meet the growing LTC needs of an aging population or to respond to Canadians' desire to age at home. Publicly funded home care services are limited, and significant unmet needs are preventing many from aging at home. Services are not tailored to recipients' circumstances and available family supports, and help with daily household tasks often does not qualify for public funding. There is often little continuity of care, as recipients receive services from different caregivers. Hence, family members and friends who step in to fill these gaps tend to report high levels of distress and burnout.

Those with high care needs, including those with dementia, will continue to require institutional care regardless of access to home care support. The pandemic has further demonstrated that new investments are needed to improve the quality, safety and humanity of these institutions.[14] The supply of formal home care services is also insufficient to meet current or future demands. To address rapidly growing LTC needs over the next few decades, immediate investments are required to improve institutional care and to expand support for home care along the full spectrum of care needs.

Cash benefits have promise as *part* of the solution for financing and delivering LTC services to Canada's aging population. These benefits could compensate for some of the shortcomings of formal home care services. They empower people to organize and manage their own care according to their circumstances. By pairing cash payments with appropriate regulations and integrating them into their public LTC services systems, other OECD countries have expanded the public supports available for older adults to age at home.

The experiences of the Netherlands and Germany, however, show that provincial and territorial governments must be cautious if they are to expand cash benefits for LTC. The uptake, satisfaction with and effectiveness of cash benefits in the Canadian context would depend on the regulations directing how the benefits are accessed and spent. Inadequate regulations could lead to major increases in public spending and jeopardize some women's long-term employment prospects. Furthermore, cash benefits alone may not improve the quality of care provided at home.

[14] Over two-thirds of nursing home residents had dementia in 2015-16 (CIHI, n.d.). By 2038, almost 3 percent of the Canadian population (1.125 million people) are expected to have dementia (Canadian Institutes of Health Research 2010).

Provincial and territorial policy-makers should thus target cash benefits to those with low to moderate LTC needs. They should also work with the federal government to implement additional measures to ensure that informal caregivers do not suffer major long-term financial setbacks as a result of balancing care and work. Cash benefits are only part of the solution to help older Canadians have greater control over their care and be able to age at home when possible. The reality is that all forms of LTC care – institutional and formal and informal home care – are in need of investment from Canadian governments. Other countries are much further along than Canada is in designing policies to help older adults age at home. Canada must catch up quickly, as demographic pressures loom and risk exacerbating gaps and failures in our LTC systems.

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