A Systematic Review of the Literature on Combining Work and Eldercare in Canada

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EXECUTIVE SUMMARY

Statistics Canada predicts that by 2031, seniors will account for between 23% and 25% of the total population, almost double the current proportion of 13%. In 2002, 1.7 million Canadians aged 45-64 provided care to an elderly person with long-term disabilities or physical limitations, and 7 out of 10 of these caregivers were also employed. For all employed caregivers, but particularly those who provide care on an on-going, intense basis and/or those who are called upon to provide major assistance when health crises occur, managing work demands and caregiving can pose serious challenges. Economic, social and personal costs of caregiving, including effects on caregivers’ physical health, mental health, and social well-being and high levels of caregiver burden can ultimately lead to high rates of absenteeism, depression and distraction, low morale, impaired productivity, and withdrawal from the labour force including involuntary retirement.

Population projections also predict an already emerging shrinking of the labour force as the population ages. Increasingly, employers in certain regions of the country and specific sectors are recognizing that the retention and recruitment of skilled workers and supports and initiatives to support their productivity, engagement, and health are a business imperative. For these reasons and others, finding ways to maintain the health and capacities of the increasing number of employees who combine work and eldercare is extremely timely as both an economic and social policy issue.

This project represents a meaningful and productive partnership between the University of Guelph, the Centre for Families, Work and Well-Being and Homewood Health. Its goal is to examine recent Canadian research and practice in order to comprehensively explore the following four themes associated with the topic of combining the demands of paid work with those of providing eldercare:

- Gender, work and eldercare
- The needs of employed eldercare providers and their workplaces
- Employee assistance programs (EAPs) and other organizationally-based family-friendly programs/policies
- Work and bereavement
The report addresses each theme in turn, beginning with a basic overview of what we already know, what issues are currently emerging, and what implications can be drawn by connecting research to policy and practice. It brings together quantitative, qualitative, and experiential knowledge obtained from the academic literature and government reports, from other researchers, from practitioners, and from employed eldercare providers themselves into a systematic review of the topic.

Key Points Related to Gender, Work and Eldercare

1. While roughly equal numbers of men and women age 45 to 64 are involved in informal caregiving to seniors, women are more likely to provide more hours (a higher intensity) of care, more personal care, and assume a disproportionate amount of responsibility for care.

2. Men are more likely to combine fewer hours of care with more hours of paid employment and tend to express less guilt as the amount of care and support they provide increases. Men are most likely to provide more hours of care to an ailing spouse or co-resident parent.

3. Caregiver strain (a measure that combines physical, financial and mental stress attributable to caregiving demands along with feelings of being overwhelmed) is most directly predicted by the amount of time employed caregivers spend providing care and the amount of responsibility they have for providing and managing care and support for a family member with a serious or chronic illness or an older family member with on-going support needs.

4. Consequently, high levels of caregiver strain and family-to-work conflict are more prevalent among women with significant dependent care responsibilities, especially those with fewer financial resources, limited flexibility at work, and limited access to support from community agencies and other family members. Caregiver stress is also considerably higher among those who feel they had no choice in assuming responsibilities for caregiving.

5. Overall, women make more workplace adjustments than men, including changing their work patterns, reducing their work hours, and foregoing additional training.
6. Caregiving for an older family member is more likely to be a reason for withdrawal from the labour force among women than men. In 2002 more than 21% of retired women age 45-64 who provide eldercare, but only 8% of male caregivers who retired said that the need to provide care was one of the reasons they retired when they did. Among currently employed caregivers, it is estimated that as many as 1 in 5 women and 1 in 10 men could retire sooner than planned because of caregiving responsibilities.

7. Overall, women incur greater non-financial and financial costs as a result of caregiving that affect their careers and their health. Caregivers’ jobs and incomes may be at risk. Financial costs include reduced wages, savings, and pension contributions, with implications for caregivers’ long-term financial security.

8. Emerging themes include:

- The assumption that most women have “choices” around balancing work and eldercare responsibilities may be false. An important question is: Do public policies and workplace norms reinforce traditional gender expectations, creating more hardship for women and for men?

- Assumptions about the availability of rural women to provide care should be viewed with caution. Rural communities vary considerably in terms of the resources available to meet the needs of aging seniors; many have been affected by service cuts and hospital closures.

- Women who work in rural areas and those who work as health and social service professionals in care professions may experience even greater difficulties when trying to meet the demands of both work and eldercare at the same time.
Key Points About the Needs and Experiences of Employed Eldercare Providers and Their Workplaces

1. Combining work and eldercare will be increasingly common. Employers who ignore this issue will risk higher rates of absenteeism, stress, lower productivity, and increased difficulties recruiting and retaining skilled workers and maintaining the engagement and organizational commitment of valuable employees.

2. Employees’ caregiving involvement may be on-going and/or driven by unpredictable crises, and their involvement or potential involvement may span a number of years. Some employees provide care and support for family members at a distance and must travel to provide the care and support their family member(s) need. Long-distance caregivers face the challenges and the complexity of locating, maintaining and communicating with service providers, agencies and health professionals in another location - sometimes in another city, province or country with different service systems.

3. According to a 2001 survey of over 31,000 employees in large and medium-sized Canadian workplaces in the public, private and non-profit sectors, 26% of employees reported experiencing high levels of caregiver strain. Caregiver strain is positively correlated with absenteeism due to eldercare problems and emotional, physical and mental fatigue. The direct costs of absenteeism to employers due to high levels of caregiver strain are calculated to be just over $1 billion per year; indirect costs are estimated at another $1 to $2 billion.

4. Other survey data collected by Statistics Canada indicate high levels of stress and guilt among employed caregivers. Both are exacerbated by combining long work hours with caregiving.

5. Employed caregivers have identified four main needs: respite/relief, financial compensation, information on long-term illness and caregiving, and flexible work arrangements. Employed providers need to be supported in their efforts to do their best at home and at work.
6. Many employed caregivers are reluctant to identify their needs for support in the workplace. Men who are involved in personal care, in particular, are more likely to perceive their workplace to be unsupportive of their involvement in caregiving.

7. Managers need additional information and support to help them effectively manage work redesign and flexible work options. Informal support by managers is as, or more, important as formal workplace policies.

8. Co-workers can provide substantial support to employed eldercare providers.

9. It is important to ameliorate difficulties combining work and eldercare with the diversity of Canadians in mind. Recent immigrants may have difficulty accessing information and services and find that cultural values conflict with pressing economic needs. Aboriginal Canadians may also face challenges both on and off-reserve in accessing important services and supports.

10. Many employed eldercare providers can manage both work and care roles effectively, as long as they have some flexibility and support. The opportunity to be effective and successful at work can serve as an important buffer and contributor to caregiver’s health and resilience. The capacity to provide care and support can provide a strong sense of purpose and satisfaction.

Key Points About EAP Services and Other Workplace Supports

1. EAP services, family-friendly benefits, alternative workplace arrangements and access to public policies that provide job-protected family leave and compassionate care leave and benefits are inequitably available to employees. There is a need for review and redesign of some of these policies and practices if they are to be more effective in meeting the needs of employed caregivers.

2. There is some concern about the value and cost-effectiveness of traditional EAP services in helping employees address work-life issues, particularly eldercare.

3. There is room for innovative models and partnerships between employers, community agencies, researchers and governments. Opportunities should be
developed to educate employees, make information about health and social services more accessible, and help them anticipate ways to address eldercare issues.

4. Creative initiatives and new policies may be required to address the needs of employees with eldercare responsibilities in small businesses and in rural communities.

5. Employees have inequitable access to opportunities for family leave, flexible scheduling, and other workplace supports and there is a mismatch between employees’ needs and access to eldercare information through workplaces. Public policies need revision and strengthening to support employees with work and eldercare responsibilities. Limited home care supports, assisted living options, and lack of accessible community-based support for caregivers are all issues that require a public policy response.

Key Points About Work and Bereavement

1. Work and bereavement issues is an area in which there is little research. Current bereavement policies in most provinces and workplaces provide only a few days of unpaid leave, which often is not adequate – especially for employees whose loved ones live in another city or country. Additional time may be needed to settle an estate or attend to related matters.

2. Grief can be manifested long after the death of a loved one. Eldercare providers who work in the helping professions may be at particular risk.

3. Grief can also affect co-workers, both as friends and colleagues. Information about how to support grieving co-workers would be helpful for managers and co-workers.

This systematic review identifies the need to better support employees with eldercare responsibilities – a group that is increasingly visible, but whose complex and unique needs remain largely unaddressed. There are many paths that can be explored for this purpose, and it is urgent that multi-pronged strategic efforts begin soon to bring about significant change in communities, in workplaces, and in public policies.
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INTRODUCTION

A systematic review that explores the experience of combining work with eldercare is very timely. Statistics Canada predicts that by 2031, seniors will account for between 23% and 25% of the total population, almost double the current proportion of 13% (Statistics Canada, 2005a). It is also startling to realize that by 2002 1.7 million Canadians aged 45-64 (16% of that age group) provided care to almost 2.3 million seniors with a long-term disability or physical limitation. Seven out of 10 of these caregivers (1.2 million) were employed, most often on a full-time basis (Stobert and Cranswick, 2004).

The proportion of working-age Canadians providing care and support to a parent or parent-in law, a spouse/partner or sibling, or an extended family member or close friend over the age of 65 is expected to increase over the next two decades as the population and the work force ages. With the employment rate for women, and particularly for middle-aged women, having increased substantially in the past two decades (up from 44% in 1985 to 64% in 2005 for women aged 45 to 64) and the fact that smaller families mean fewer adult children are available to care for their aging parents, it is likely that both men and women increasingly will be pulled in two directions as they attempt to address the demands of work and family care at the same time (Pyper, 2006). Maintaining a healthy balance between paid employment and caregiving will be a priority for many Canadians.

Similarly, research in the U.S. suggests that by 2010, one in two employees will provide some care or support to an elderly person (Brown, 2005) and that in the next five years, 37% of the U.S. workforce will be more concerned about caring for elderly relatives than caring for a child (California Department of Personnel Administration, 2004).
According to the most current Canadian research on eldercare conducted by Statistics Canada in 2002,¹ most employed eldercare providers (age 45-64) provided care or assistance to more than one older adult and most have done so for over two years. At least 75% of employed caregivers provide care to close kin (a spouse, parent or parent-in-law), and most live close to the care recipient (Walker, 2005). 2001 census data revealed that most employed caregivers were not living with the person for whom they provided care and tended not to be the primary caregiver (the person who is identified as providing the most hours of care and has greatest responsibility for providing care and support) (Fast & Keating, 2001).

Caregivers provide a variety of tasks for their senior family members/friends and those who are not engaged in eldercare activities are often surprised by the nature and extent of these necessary tasks. Activities associated with eldercare include assisting with household tasks, paying bills, driving seniors to the doctor or other appointments, and assisting with shopping and food preparation, as well as lifting and moving (Decima, 2002; Keating, Fast, Frederick, Cranswick & Perrier, 1999). Approximately one in four caregivers provide basic personal care in the form of assistance with dressing, bathing, walking, feeding and toileting. A small percentage provides assistance with wounds or injections (Decima, 2002). Many caregivers report that a key task is “checking in” or monitoring the needs and emotional well-being of care recipients. Individual caregivers may also be involved in arranging and monitoring services, gathering information, and strategizing how to share care and support functions with other family members, friends, and community agencies.

In addition, a number of employed caregivers provide care at a distance from where they live, which often poses significant challenges for them in the workforce.

¹ The 2002 General Social Survey (cycle 16) focused on “Aging and Social Support” and consisted of a telephone survey of individuals 45 years and over covering approximately 25,000 respondents living in private homes in the 10 provinces. The survey focused on information regarding informal, unpaid care/assistance provided to close friends and family members aged 65 years and over. Care providers in this survey are defined as individuals 45 years and over who reported providing assistance in the previous 12 months with at least one task to an individual 65 years and over because of a long-term health problem. The 1996 General Social Survey was not limited to those age 45 and older and provided information on care to family members and close friends, a portion of whom were not seniors.
Recent local data suggests that more than one in 10 seniors aged 70 and older have no children living within one-and-a-half hours of travel time (United Way, Guelph-Wellington, 2006). For both men and women, distance is a factor that has a negative effect on the amount and frequency of assistance provided by employed male caregivers, but not employed female caregivers. Women drive further and provide more care than their male counterparts (Joseph & Hallman, 1996). Long distance caregiving has also been shown to be particularly stressful for those who care for seniors in rural areas where services are spread out over greater distances or lacking altogether (Joseph, Leach & Turner, 2007).

Activities that long distance eldercare providers engage in include connecting (by telephone or e-mail) to support services that are often only open during the day, finding and monitoring access to home care and other services, monitoring the health status of the senior throughout the day and evening, and traveling sometimes significant distances without warning at all hours in crisis situations (Joseph, Leach & Turner, 2007). While these activities pose challenges to the person who is caring for one senior, they create even greater challenges to approximately one in ten caregivers who are caring for more than one senior at the same time (Decima, 2002; Joseph, Leach & Turner, 2007).

Though some caregivers provide only occasional care and support, on average, employed caregivers report providing almost 20 hours of care per month (Stobert & Cranswick, 2004). In 2002, 44% of employed women caregivers and 27% of employed male caregivers provided an average of 4 or more hours of care per week, most often in conjunction with full-time work (Pyper, 2006).

While individuals may willingly provide care and support to close friends and family members and derive satisfaction from doing so, it has been shown that caregiving can result in significant personal costs to caregivers and to their families -- costs that can compromise the quality of care provided and the sustainability of family and friend caregiving networks. Significant health consequences; guilt, depression and anxiety; marital/family conflict and more limited opportunities for social interactions with others - sometimes leading to isolation; increased out-of-pocket expenses; and employment-related costs (absenteeism, reduced hours, work-family conflict, having to quit work or
turn down opportunities) are evident in various studies of caregivers (Lero, Keating, Fast, Joseph & Cook, 2007).

Of course, not all caregivers are affected to the same degree or in the same ways. In fact, Statistics Canada data suggest that, on average, care providers report the same level of stress and life satisfaction as those not providing care (Stobert & Cranswick, 2004). Nonetheless, some caregivers are clearly at risk or are vulnerable to experiencing significant levels of caregiver strain that can impact on their health and well-being. Care recipients’ functional capacities, cognitive capacities, problem behaviours, deterioration, pain, depression, and illness trajectory are factors that influence both caregiving intensity and costs. Caregivers who are in poor health themselves, who have limited financial resources, little or no flexibility at work, and minimal support from others while providing significant amounts of care are most likely to experience serious, adverse impacts of caregiving on their physical and mental health (Lero et al., 2007). Emotional consequences of caregiving are believed to be widespread. Caregiver burden may be experienced as a sense of being tied down, lack of time for oneself, difficulty in getting a break (Kuuppelomäki, Sasaki, Yamada, Asakawa & Shimanouchi, 2004). Common outcomes in the literature are feelings of guilt, anger, anxiety and depression.

In their review of 41 studies published between 1990 and 1995 on caregivers to someone with dementia, Schultz, O’Brien, Bookwala, and Fleissner (1995) noted a consistent finding of elevated levels of caregiver depression. A second conclusion was that negative effects of caregiving on caregivers’ mental health and emotional well-being are related to caregiving tasks and worry about the decline and anticipated death of the care receiver. Grov, Gossa, Sorebo & Dahl (2006) found that depression was the largest contributor to caregiver burden and mediated the effects of other variables, such as patient symptoms and social support.

A recent survey of almost 32,000 Canadian employees in medium and large private, public and non-profit organizations revealed that approximately one in four employees reported experiencing high levels of caregiver strain (physical, financial or mental stress), primarily as a result of eldercare responsibilities (Duxbury & Higgins, 2005). While many factors can influence caregivers’ health, well-being and difficulties combining work and eldercare, as noted above, several studies show that one of the most
significant predictors of caregiver strain among employees is the number of hours they spend each week providing care to an elderly dependent (Duxbury & Higgins, 2005; Pyper, 2006), which itself reflects a combination of care needs and the lack of other supports. The concept of caregiving intensity in most of the literature suggests more than hours of care – it also suggests having primary or sole responsibility for providing care -- often personal care, such as feeding, bathing and toileting, and sometimes includes care at night, which may result in caregivers being exhausted, anxious and sleep deprived – a circumstance associated with caregiver burnout and increased risk of physical illness and injury. As women tend to provide more care, more personal care, and assume more responsibility for care, it is not surprising that they are more likely to experience more adverse effects of caregiver stress – and to incur both short and longer-term costs associated with caregiving. This statement foreshadows our later discussion of gender, work and care.

Interestingly, being employed does not appear to reduce the amount of time middle-aged people spend providing care, although those who work long hours (most often men) are less likely to provide more than a few hours of care or to describe themselves as a primary caregiver. The average time spent by all caregivers age 45-64 on eldercare tasks in 2002 was 22.9 hours, compared to an average of 19.9 hours among those whose main activity was working (Stobert & Cranswick, 2004). Similarly, Rosenthal, Hayward, Martin-Matthews & Denton (2004) found that employment status (full-time, part-time or not employed) was not related to the amount of time women spent helping older parents or in-laws (see Table 1). Caregivers do what is needed to be done, which explains, in part, why caregivers who work full-time may experience greater stress. Analysis of 2002 data revealed that high-intensity caregiving (defined in the GSS as more than four hours of care per week) had a substantial effect on over half of the women caregivers sampled, regardless of the number of hours of paid work in which they were involved (Pyper, 2006).
Table 1: Help to Parents (in-law), by Employment Status of Daughter (in-law), 1996

<table>
<thead>
<tr>
<th>Type of Help Given</th>
<th>Employed full-time (n=633)</th>
<th>Employed part-time (n=197)</th>
<th>Not employed (n=348)</th>
<th>Total (n=1,178)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Instrumental Help</td>
<td>Percent Providing Assistance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any Help</td>
<td>16.1</td>
<td>12.7</td>
<td>17.2</td>
<td>15.9</td>
</tr>
<tr>
<td>Meal Preparation</td>
<td>7.9</td>
<td>6.1</td>
<td>8.6</td>
<td>7.8</td>
</tr>
<tr>
<td>Cleaning</td>
<td>7.1</td>
<td>6.6</td>
<td>9.2</td>
<td>7.7</td>
</tr>
<tr>
<td>Home Maintenance</td>
<td>3.6</td>
<td>2.5</td>
<td>5.5</td>
<td>4.0</td>
</tr>
<tr>
<td>Grocery Shopping</td>
<td>9.3</td>
<td>7.1</td>
<td>10.4</td>
<td>9.3</td>
</tr>
<tr>
<td>Transportation</td>
<td>8.4</td>
<td>8.6</td>
<td>11.5</td>
<td>9.3</td>
</tr>
<tr>
<td>Banking, etc.*</td>
<td>4.7</td>
<td>3.6</td>
<td>8.6</td>
<td>5.7</td>
</tr>
<tr>
<td>Personal Care</td>
<td>5.1</td>
<td>3.6</td>
<td>6.3</td>
<td>5.2</td>
</tr>
<tr>
<td>Non-instrumental Help</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Checking Up</td>
<td>38.5</td>
<td>34.0</td>
<td>32.5</td>
<td>36.0</td>
</tr>
<tr>
<td>Emotional Support*</td>
<td>14.1</td>
<td>7.1</td>
<td>12.1</td>
<td>12.3</td>
</tr>
</tbody>
</table>

*p < 0.05

Source: Rosenthal, Hayward, Martin-Matthews and Denton, 2004
Based on General Social Survey of Canada, 1996

Studies from the U.S. suggest that the aggregate cost of providing eldercare in lost productivity to business was estimated to be $11.4 billion per year in 1999. By 2006, that estimate had risen to over $17 million (MetLife Mature Market Institute & National Alliance for Caregivers, 1997) as shown in Table 2. It should be noted that this is considered to be a very conservative estimate as it is difficult to calculate the costs to businesses that relate to health care, work accommodations, and foregone employee training or promotions related to caregiving responsibilities. In addition, the costs associated with employed caregivers who had to reduce their work status to part-time in order to provide eldercare, who provide fewer hours (light intensity) of care to seniors, or who provide care to seniors a significant distance away were not included in this estimate. If all of these additional costs were included, it is speculated that the total costs to U.S. business associated with eldercare could exceed $29 billion per year (MetLife Mature Market Institute & National Alliance for Caregivers, 1997).
Table 2: Breakdown of Total Estimated Cost to U.S. Employers of Full-time Employed Intense Caregivers (U.S. dollars)

<table>
<thead>
<tr>
<th>Cost per Employee</th>
<th>Total Employer Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Replacing Employees $403</td>
<td>$2,822,461,694</td>
</tr>
<tr>
<td>Absenteeism $489</td>
<td>$3,430,263,991</td>
</tr>
<tr>
<td>Partial Absenteeism $18</td>
<td>$824,512,465</td>
</tr>
<tr>
<td>Workday Interruptions $404</td>
<td>$2,832,971,162</td>
</tr>
<tr>
<td>Eldercare Crisis $232</td>
<td>$1,628,347,501</td>
</tr>
<tr>
<td>Supervisor Time $111</td>
<td>$780,268,472</td>
</tr>
<tr>
<td>Unpaid Leave $206</td>
<td>$1,447,420,001</td>
</tr>
<tr>
<td>Full-time to Part-time $478</td>
<td>$3,349,727,407</td>
</tr>
<tr>
<td><strong>Total</strong> $2,441</td>
<td><strong>$17,115,972,695</strong></td>
</tr>
</tbody>
</table>

Source: MetLife Mature Market Institute, National Alliance for Caregiving, 2006

For all employed caregivers, but particularly for those who are forced to cut back working hours in order to provide eldercare, take lengthy unpaid leave, or find they have to leave the workforce, the economic costs of caregiving can be significant and are often overlooked. Yet despite the costs to both employers and employed caregivers, it is estimated that unpaid caregiving has a replacement value that saves Canadian taxpayers over 5 billion dollars annually (Fast & Frederick, 1999). Of course, caregiving is also of major personal value to family members, contributing immeasurably to care recipients’ comfort and well-being and to care providers’ sense of purpose and fulfillment.

There is considerable diversity among employed eldercare providers in the number of hours individuals engage in paid work while caregiving, the flexibility accorded to them, and the nature of workplace demands (e.g. whether some work can be done at home) that prevents the issue of accounting for hours of work and hours of care from being perfectly clear cut. Combining work and care can include more or less work with more or less care. Typically, individuals with significant eldercare responsibilities who continue to work long hours are able to do so because other family members and/or paid care providers are available, reflecting the fact that a network of individuals may be involved in providing care and support to seniors. Maintaining that network and negotiating care responsibilities is another facet of caregiving, and changes in the
availability of network members may result in greater demands for an individual who had previously not been intensively involved in care on a regular basis.

While many analyses focus on gender, employment status, and number of hours of care provided, caregivers are diverse in other ways as well. There is evidence that cultural background and immigrant status serve to reduce access to formal services available to seniors, which, in turn, can increase the demands made upon employed caregivers to help facilitate or navigate service networks or convey information to service providers (Pinquart & Sorensen, 2005). Immigrants, especially those who have arrived most recently, reportedly use fewer health care services than those born in Canada due to language barriers, lack of knowledge about the Canadian health care system, and cultural norms. As a result, family/friend caregivers of older immigrants may be under heavier pressure to provide care without support from health care professionals (Lero, Keating, Fast, Joseph & Cook, 2007; Pinquart & Sorensen, 2005).

It is therefore not difficult to recognize the very complex nature of combining employment and eldercare, and the fact that many different variables – including the nature of workplace demands and workplace supports, the nature of care demands, gender role expectations, the availability of resources to support loved ones’ health and well-being, financial resources, whether care recipients are co-resident or nearby or care is done at a distance, and cultural and personal characteristics impact upon informal caregivers as they attempt to be both effective at work and responsive to care needs.

The goal of this project is to examine Canadian research and practice information and to identify emerging themes related to the topic of combining paid work and eldercare. Our aim is to present the issues, the gaps and some proposed solutions in a practical way that will encourage reflection and inform policy and practice. This project represents a meaningful and productive partnership between the University of Guelph, the Centre for Families, Work and Well-Being and Homewood Health. Dr. Donna Lero, Jarislowsky Chair in Families and Work, Research Associate Gillian Joseph and Dr. John Hirdes, Director of Research at Homewood Health and Professor of Gerontology at the University of Waterloo jointly defined the areas of focus. The following report explores issues related to the following four themes:
• Gender, work and eldercare
• The needs of employed eldercare providers and their workplaces
• Employee assistance Programs (EAPs) and other family-friendly programs / policies
• Work and bereavement

We begin by describing how this review is organized, highlighting the strength of its more nontraditional, holistic approach. Each of the four main themes is addressed in turn, beginning with a basic overview of what we already know, what issues are currently emerging, and what implications can be drawn by connecting research findings to policy and practice. The information presented under the sections “What Do We Know Already?” provides a brief overview of main findings from the literature, not only in the sociological and psychological journals, but also from journals in other fields, such as human geography, medicine and the humanities. The “Emerging Themes” sections include a discussion of where current research is headed which, in some cases, is focused on extending and deepening what is already known, as well as exploring issues or concerns that are new or relatively undeveloped.
ORGANIZATION OF THE PROJECT/METHODOLOGY

The definition of what constitutes a systematic review is a matter of debate in academic circles. For example, in some arenas systematic reviews only include academic, peer-reviewed literature and are restricted to knowledge gained through quantitative randomized controlled trials. However this approach ignores the wealth of information that can be gained from a wider range of sources including qualitative studies, newspaper articles, government and agency reports, web-based materials and interviews with key informants which, when brought together with quantitative analyses, can provide more detail, rich insights, and identify important gaps in our understanding. For this systematic review a broad range of sources were included, encompassing both quantitative and qualitative studies. Although a few relevant studies from the U.S. and the U.K were included, we deliberately focused mostly on Canadian research and information. The project included five main activities:

- an extensive literature search and review;
- discussion and information with peers through a workshop on combining work and eldercare we provided at a provincial conference on Gerontology;
- key informant interviews;
- discussion and information sharing among researchers and practitioners with caregivers at a university-sponsored forum on combining work and eldercare; and
- a 2-day academic Roundtable with researchers who are considered to be nationally recognized experts in caregiving, and work and care.

Our first step was an extensive literature review focusing on the themes of central interest. This resulted in a bibliography of over 200 Canadian peer-reviewed journal articles and approximately 20 secondary articles from Canadian magazines, newspapers and reliable internet sources. In order to provide up-to-date information, this review focuses primarily on articles published from the year 2000 forward, with a few exceptions.

Second, included in the review is information gained through a workshop that we ran as part of this project at the 2006 Ontario Gerontology Association meetings entitled
“Balancing Work and Eldercare”. This workshop brought together four researchers from three Ontario universities who presented their findings and led interactive discussions with geriatricians and practitioners on the topic. These researchers included Dr. Lori Campbell from McMaster University; Jean Lillie, a Ph.D. candidate from the University of Guelph; Dr. Mark Skinner from Trent University, and Gillian Joseph, Research Associate from the University of Guelph.

Third, interviews with six key informants helped identify research studies and guided us toward important issues that, in some cases, lay outside of the mainstream academic discourse on the topic. These key informants included a professor of Gerontology, a director of research for a community-based caregiving association, a director of a national caregiver association, a geriatrician, a care worker at the Alzheimer Society, and an eldercare provider who also works full-time as a professional manager in the geriatric mental health support sector.

Fourth, we gained insight from organizing and co-presenting at an employer-sponsored public forum entitled “Balancing Work and Eldercare” at the University of Guelph which drew an unexpectedly high number of participants including employers, community partners and agencies, as well as the general public. Offered in the spring of 2006, a keynote speaker, several expert panelists and an employed eldercare provider presented information and answered the often challenging questions posed by the audience. Information was provided and discussed on the topics of good nutrition and the art of feeding seniors, and supports and programs offered by Community Care Access Centres. Advice and information was provided by professionals who work with seniors with cognitive problems and their families, and a gerontology social worker also proved to be an excellent resource. Plans are underway to hold a second forum in 2008 in response to the feedback.

Finally, a two-day academic roundtable on research in work and eldercare was held at the Centre for Families, Work & Well-Being on November 23 and 24th, 2006, which brought together 22 leading Canadian researchers on the topic. The objectives of this roundtable were two-fold:

1. To discuss issues and identify gaps that exist in current research on the intersection of work and eldercare, and
2. To form a research network to move forward on issues associated with work and eldercare, creating a research agenda and potential partnerships/communities of interest for a larger initiative.

Thus, this report brings together quantitative, qualitative and experiential knowledge obtained from the literature, from other researchers, from practitioners, and from employed eldercare providers themselves into a systematic review to explore issues pertaining to combining work and eldercare from the perspectives of employees, recipients and employers.
1. Gender, Work and Eldercare

The topic of gender is fundamental to a review of work and eldercare, and there were very few articles or discussions that did not raise this point. Morris (2001) notes that caregivers and their care recipients are often left out of the discussions that determine policy development because few services or policies include an analysis of the impact that gender may have.

A. What Do We Know Already?

1. Employed women carry a disproportionate amount of responsibility for providing care to seniors compared to employed men, and typically provide more hours of eldercare and more personal care.

2. The adjustments that many working women make in order to provide eldercare have consequences for their careers, their health, and their financial security.

3. Employed men (particularly those who work full-time) who provide eldercare report that their activities are different from those of employed women caregivers; however employed male caregivers who provide care to a spouse/partner or family member who is co-resident often provide significant amounts of eldercare and may experience considerable strain.

Although roughly the same percentage of employed men as women are eldercare providers, it has long been known that women provide more hours of care, more personal care, and, in general, carry a disproportionate amount of responsibility for eldercare in comparison to men, particularly at higher care intensity levels (Gazso, 2004; Joseph & Hallman, 1996; 1998; McElwain, Korabik & Rosin, 2005; Morris, 2001). One of our key informants, Dr. G. (a geriatrician), noted that it is predominantly women who she sees in the role of caregiver in her busy practice, even if the senior who is receiving care is related to the caregiver’s husband.

According to Statistics Canada, in 2002, men made up about 53% of employed caregivers aged 45-64; however, as shown in Figure 1, men and women differ in the intensity (number of hours of care) they provide. “Of the employed men who provided eldercare, one third (34%) spent an average of one hour or less per week compared with
24% of women. On the other hand, their female counterparts were more likely to be high-intensity caregivers (four or more hours per week) – 44% vs. 27%” (Pyper, 2006: 6). On average, employed women spent 26.4 hours per month providing eldercare, while employed men provided 14.5 hours of care.

Figure 1: Men Caregivers Are More Likely than Women Caregivers to be Employed: They Are Also More Likely to be Low-intensity Caregivers

Men and women evidence different patterns in the type of care tasks in which they are involved, reflecting rather traditional gender roles. As shown in Figure 2, employed women spend about three times as much time providing care in the recipient’s home in domestic activities (housekeeping, meal preparation, etc.) and in providing personal care as employed men. Men spend slightly more time providing assistance with transportation and twice as much time as women in outside activities such as house maintenance and yard work – tasks typically associated with men.
Men’s and women’s involvements in caregiving, in part, reflect differences in the number of hours of paid work they combine with care, as male caregivers are more likely than female caregivers to be engaged in full-time employment and to work longer hours (Comfort, Johnson & Wallace, 2003; Keating et al., 1999; Morris, 2001). In 2002, almost all employed male eldercare providers (93%) were employed full time (30 or more hours per week), as were 72% of employed female caregivers; however, within those full-time categories, men are far more likely to work longer hours. Only 20% of employed women caregivers worked more than 40 hours per week at a job or business; by contrast, 47% of employed male caregivers worked more than 40 hours per week (Pyper, 2006). These figures, in part, reflect the fact that women are more likely to make changes in the number of hours they work to accommodate care demands, and, in fact, are often expected to do so. Men who work long hours generally provide fewer hours of care, in part because there are others with whom they share care (typically women) who
provide more hours of care. As noted previously, in addition to providing more care, women also spend more time driving to provide care to relatives who may live some distance from each other, as well as from their own home and work locations.

Are there men who evidence caregiving patterns that are similar to women’s – i.e., more hours of care, more personal care, more responsibility for care? The answer is yes, of course. Based on 2002 data, more than 160,000 men provided higher intensity eldercare (minimum of four hours of care per week). Research suggests that men without siblings, as well as men who have lower incomes, tend to provide intensive eldercare that is more nontraditional in nature (Campbell & Martin-Matthews, 2003). Men are also far more likely to provide intensive care to a spouse or co-resident parent, but often will do so while maintaining full-time employment (Keating et al., 1999).

Research shows that employed women caregivers are twice as likely as their male counterparts to change work patterns and to reduce their work hours in order to provide care (Hunsley, 2006). Consequently, Habtu and Popovic (2006) found that women were more likely than men to report a reduction in income associated with caregiving, and to experience more social and personal consequences such as changes in social activities, holiday plans, and reduced sleep and health changes. Unfortunately, it appears that the flexibility women gain through accepting part-time work or job sharing often comes at the price of reduced wages, career enhancement opportunities, pension benefits and access to non-wage benefits (Comfort, Johnson et al., 2003). These economic costs have longer-term consequences for women, and in some cases, can contribute to a greater risk of poverty for women in their later years.

Because providing personal care is a strong predictor of making adjustments to work, and because women provide four times the amount of personal care provided by their male counterparts, women are far more likely to make work-related adjustments such as reducing a full-time workload to part-time, coming in late or leaving early, or making other often complicated adjustments in order to combine work and care (Walker, 2005). Figure 3 highlights these differences. When employees have little choice other than to reduce hours, leave the workforce or forego career enhancement opportunities, organizations (particularly those that do not support caregivers or enable flexible work
options) will suffer the effects of losing valuable employees and/or foregoing significant returns on skill development investments.

![Graph showing work patterns and changes in employee numbers]


**B. Emerging Themes on Gender, Work and Eldercare**

**Employed Female Providers**

1. Contrary to the way that organizations have viewed the domain of family as it impacts upon work, research shows that the responsibilities for work and family do not exist in separate spheres, but are interrelated.

2. The assumption that most women have “choices” around balancing work and eldercare responsibilities may be false. An important question is: Do public policies and workplace norms reinforce traditional gender expectations for women to provide more care and create additional hardships for both men and women who care?

3. Assumptions about the availability of women to provide care in rural communities should be viewed with caution.
4. Working women in caregiving professions who provide both informal and formal eldercare are in “double jeopardy”, with increased expectations to manage caregiving at home and at work.

5. There is evidence that workplaces still assume that workers can undertake (or should be able to manage) their employment tasks free of interference from their domestic responsibilities (Hunsley, 2006). This is also embedded in workplace policies and practices that assume that the activities of work and family are two different aspects of a caregiver’s life that unfold separately, are distinct from each other, and can be scheduled to avoid conflict or interference. Traditional organizational perspectives consider work and family as dual or separate spheres, treating women’s responsibilities to family as something that is usually opposed to or potentially competing with the responsibilities of employed labour and/or career advancement (Grahame, 2003). Much of the research in this area is influenced by the work of industrial organizational psychologists who tend to emphasize the ways in which eldercare and other family responsibilities affect employee productivity (Medjuck, Keefe & Fancey, 1998). However, traditional definitions of the family and the disregard for the gender-specific nature of private labour within the home ignores the broader social and economic context in which employed eldercare providers exist (Medjuck et al., 1998). In contrast, others view the relationship between work and family as bidirectional, interdependent and interrelated. They point to the fact that there is no separating these spheres when, for example, women must purposefully look for employment with organizations that offer family-friendly benefits that meet their family needs and their needs as caregivers (Ferrer & Gagne, 2006; Grahame, 2003). This perspective re-focuses the lens on the impact that caring has on the worker rather than on the workplace, analyzing the consequences for women’s lives, of which family and work are only a part (Grahame, 2003; Medjuck et al., 1998).

Reflecting on what we know about the accommodations that many working women must make in order to provide eldercare, an emerging theme was posed as a question by leading researcher and Keynote Speaker, Dr. Janet Keefe, during the
Keefe posed the compelling question, “Does working women’s behaviour reflect their choices as employed caregivers, or do policies reinforce gendered expectations and a differential duty to care?” This is an important question because it may help us to see if support policies are based upon assumptions about employed female and male caregivers that reinforce traditional gender roles and inequities, resulting in less support for women and for men in combining work and eldercare.

This idea about ‘choice’ and ‘preference’ is also reinforced by research that explores how the media portrays women who are employed, and how it contributes to our understanding of the assumptions about women caregivers which, in turn, is reflected in the options that are available to them in the workplace. Gazso (2004) undertook an analysis of newspaper articles from the Globe and Mail and the National Post from the years 2000 to 2002 to explore how they portrayed women’s inequality in the workplace. In general, the articles reviewed promoted the idea that women's unequal workplace experiences were a result of their inability to "fit in" to a male work culture, their "natural" choices, and their "juggling" of work and family responsibilities. Gazso found that, given the fact that women were more likely than men to reduce or leave their full-time employment, take part-time instead of full-time employment, or use flexible work arrangements in order to provide eldercare, the reporters made assumptions that women caregivers were making choices that were “natural” or desirable to them. However, Gazso points out that what the media fail to recognize is the fact that most women undertake paid work for the same reasons men do: to earn a living to support themselves and their families – and in many cases (low-income families, single parent families, etc.) their income is essential for their own and the family’s welfare. They are no different to men in this goal. It is therefore misleading to conclude that women caregivers willingly assume competing roles, and make choices that accommodate these responsibilities that, by definition, results in their inequality in the workplace. Such reasoning puts the blame for inequality in earnings, career options and the availability and use of family-friendly options squarely on the shoulders of women themselves without considering the role that economic and social policies (or the lack thereof), along with workplace norms and
expectations play with respect to other options available to women for meeting these responsibilities (Gazso, 2004).

Bernard and Phillips (2007) point out that conventional research has used role theory to explain the stress experienced by caregivers and that one of its limitations is that it places the onus and responsibility on carers alone to manage or balance their roles. An emerging paradigm is re-positioning this view of individuals managing their multiple roles toward the concept of work-life integration or reconciliation that sees responsibility as a partnership between the employer and the employee that should be supported by public policies and community services (Bernard & Phillips, 2007).

Critics of existing family-friendly policies have shown that, in spirit at least, the needs of employees who provide eldercare have been treated as less important than those who provide care for children – leaving caregivers of elderly people to their own resources for finding ways to manage and provide for recipients. For example, Medjuck, Keefe et al. (1998) found that there are significant differences in family leave options and the length of allowable absence for employees caring for an ill child compared to those available to employees who are caring for an ill parent. There are also requirements of co-residency in many work-based benefits and tax policies that provide financial support that allow for both the longer term hands-on provision and short-term management (e.g. making arrangements for) of child care – but only the management of eldercare. Because elderly relatives are less likely to be living with their children, co-residency requirements prevent eldercare providers from accessing such policies (Fast, Eales & Keating, 2001). Moreover, since men may be traditionally more likely to manage care (i.e. arrange for it to be done), and women more likely to provide (hands-on) care, Medjuck, Keefe et al. (1998) suggest that workplace policies that support management activities alone are not gender neutral.

Studies also show that professional and non-professional women and highly educated and less educated women alike report greater time demands and more work-family stress than their male colleagues (Hughes, Lowe & Schellenberg, 2003; Nelson & Burke, 2000). Moreover, one of the critical factors that prompts executive women to leave their employers is “insufficient support for personal and family commitments” (McLean, Brady & Bachman, 2003, p. 6). It has also been suggested that executive
women, who are still a minority in Canadian businesses, can have extra demands made upon them in terms of attending outside events as a means of dispelling myths and biases about women’s abilities at higher levels and/or to mentor other professional women. However, some of these events can conflict with family obligations, particularly when they take place in the evening or when they require travel or late day meetings (Habtu & Popovic, 2006). A “catch 22” scenario is created when women must sacrifice opportunities to mentor other women towards career success because they need to attend to caregiving responsibilities, potentially diminishing their own career opportunities.

The literature suggests that the experience of combining work and eldercare may also be different depending on geographic location. Demographic changes in rural communities have led researchers and policy makers to acknowledge that (a) youth out-migration is resulting in a rapidly aging rural population that may be changing the nature of rurality altogether (Looker, 2001); (b) family economic and social dynamics may be changing in Canada as more women are entering and staying in the labour force (Beaupre & Turcotte, 2005; Ferrer & Gagne, 2006; Joseph & Hallman, 1998); and (c) because few people who leave rural areas return to their place of origin, the care that families and friends are able to provide their rurally-located elderly loved one is changing and must often be provided from a distance (Keefe 1997; Keefe, Fancey, Keating, Frederick, Eales & Dobbs, 2004). Crosato and Leipert (2006) suggest that the proportion of women in rural populations who provide informal care may be even greater due to community pressure upon women to assume traditional roles in line with gender expectations, and because of the decline in services in rural areas that downloads responsibilities for care to a greater extent to families. However, some researchers dispute this. In a comparative study comparing the likelihood that women would combine employment with helping elderly parents, Keefe (1997) challenged the assumption that there are more caregivers available in rural areas compared to urban areas. Showing that communities vary considerably across the country in their social, economic and demographic make up, Keefe emphasizes that national policies that assume that all communities face the same challenges fail to recognize regional economic, social and cultural distinctions, and in particular, the diversity of rural communities themselves. Asserting that the increasing cutbacks in rural formal support systems are an example of a policy that is predicated on
erroneous assumptions about the availability of informal care supports in some communities, Keefe (1997) emphasizes that there is an urgent need for regional analysis before policies and services are adjusted or cut. Regionally, professional employees in Quebec and Ontario are the most likely to report high caregiver strain (28 and 25%, respectively) whereas professional employees in the Prairie Provinces are least likely to do so (18%) (Duxbury & Higgins, 2003). This re-emphasizes the need for more analysis of regional and provincial needs and resources in policy development and consideration of the issues associated with eldercare in the social and economic context in which it is immersed (Keefe, Fancey & White, 2005).

While some women face challenges because of geographical location, women who work in professions related to caregiving (nurses, social service workers, home care workers, etc.) are doing ‘double-duty’ when combining eldercare with their employment as caregivers in the formal sector (Ward-Griffin, 2004; Ward-Griffin, Belle Brown, Vandervort, McNair & Dashnay, 2005). As demands for informal care to elderly relatives increase among caring professionals, the boundaries between the public and private spheres begins to blur. Some professional women caregivers are able to use their work-based connections to get medical support, or to assist others in getting medical support. Some are able to delegate care, which necessitates monitoring to make sure that it is undertaken properly. Ward-Griffin et al. found that female health professionals who were also engaged in eldercare were continually negotiating the boundaries between their professional and personal caregiving, and this often left them feeling isolated, tense and extremely exhausted. Research by Rosenthal, Martin-Matthews and Keefe (2007), who explored care management and care provision of older relatives among employed informal caregivers, shows how stressful this ‘orchestration’ of care can really be. In their study, ‘orchestrating care’, including both formal services and informal assistance from other family members or friends, is the part of care management that is most often associated with personal and job costs and causes significant stress for women in particular.

Our key informant, Dr. G. (a geriatrician) also provides eldercare to her ill parent. She notes that in her case she is able to schedule flexible time off to assist her elderly relative when needed, and is able to make up the time to compensate. To her knowledge,
however, there are no initiatives or policies in her workplace that support employees who are caring for an elderly relative. This example illustrates that some employees, particularly those in a professional capacity, are more privileged in being able to schedule their time to accommodate care needs and that there can be significant disparities in access to flexibility among workers in the same company or organization.

**Employed Male Providers**

1. The care that many men provide tends to be in line with traditional gender roles and expectations.
2. Men who are involved in traditionally female caregiving activities (bathing, feeding and other more personal care activities) often perceive their workplace to be unsupportive.
3. Men are less likely than women to talk about their role as caregivers at work.
4. Men who provide non-traditional care (e.g. personal care, more hours of care etc.) to elderly loved ones generally view their actions in line with traditional views of masculinity.
5. Male caregivers who provide more hours of care per week, like female providers, are more likely to experience caregiver strain and more family-work interference.

Roundtable Keynote Speaker Dr. Janice Keefe noted that there are several important and informative data sets that explore the experience of women who provide eldercare. However, she also emphasized that researchers need to critically examine the experiences of employed men who provide care, so that we can better understand their experiences as caregivers and how they are viewed in the workplace and in society generally.

According to Statistics Canada, in 2002, 53% of employed caregivers to seniors were men. However unlike the direct personal care that is provided to seniors by women, researchers suggest that men tend to provide eldercare more often by providing assistance for and management of financial support, transportation, home repairs and maintenance (Canadian Caregiver Coalition, 2003). As described previously, men tend to provide fewer hours of care than their employed female counterparts, and to combine fewer hours
of care with more hours of employment (Pyper, 2006). Approximately 44% of women provide four or more hours per week of eldercare (considered high intensity) compared to 27% of men who provide this amount of care (Pyper, 2006).

For employed men over 45, geographic proximity to the care recipient was the strongest predictor of changing work patterns to provide care, with those cohabiting with the care recipient more than three times as likely to report making accommodations to their work patterns as those who were not living with the care recipient (Walker, 2005). It appears that unpaid care work rarely causes time stress for men, although caring for a disabled spouse is particularly stressful for them (Frederick & Fast, 1999).

Another interesting study suggests that while it would be reasonable to speculate that caregivers who provide more care would feel less guilty about not doing enough, this is gender-specific. For example, for men, as time spent on caregiving increased, their level of reported guilt went down, while this pattern did not hold true for women caregivers (Frederick & Fast, 1999). For every additional hour of eldercare provision, men’s score on a guilt index dropped by nearly 1%, but this had no significant effect for women (Frederick & Fast, 1999). Pyper (2006) noted that longer work hours are associated with higher levels of guilt, particularly for those women who provide the lowest amount of care, but have the highest amount of work.

Some men do report that they have had to postpone educational training and job opportunities and/or to turn down a job transfer in order to provide eldercare (Fast & Frederick, 1999; MetLife Mature Market Institute, 2003). The percentage of men reporting that their family obligations resulted in delaying their plans for education, or led to foregoing a job promotion or job transfer rose from 5% to 34% as the need to provide care rose from less than 2 hours per week to 7.5 hours or more per week (Fast & Frederick, 1999). Such lost opportunities can have long-term consequences for caregivers in terms of employment, pensions and promotions, and for organizations that are not able to reap the benefits of retaining dedicated, well-trained workers (Frederick & Fast, 1999). For an employee, lost opportunities may also contribute to poor morale, which, in turn, can lead valuable employees to look elsewhere for employment.
Interestingly, no significant relationship was found between perceptions of workplace support for men who provided gender-neutral types of care (e.g., driving); while men who provided more traditional types of care activities (both traditionally female and male specific) perceived negative workplace support for their caregiving role (Campbell & Martin-Matthews, 2003). A U.S. study shows that unlike women, men are less likely to discuss caregiving responsibilities at work, and are more likely to report that neither their supervisor nor their co-workers know about their caregiver role (MetLife Mature Market Institute, 2003). This suggests that there may be a stigma attached to male caregiving in the workplace (MetLife Mature Market Institute, 2003). While the workplace may view male caregivers in a stereotyped way, Campbell and Carroll (2007) found that male eldercare providers do not see any discrepancy between providing eldercare and traditional notions of masculinity, even when they engage in eldercare activities that are traditionally considered to be feminine. For example, men in this study believed that women provided care because they were innately nurturing, while they justified their own actions as providers of care because of their commitment to the principles of reciprocity and fairness. By deliberately disassociating themselves from the traits that define femininity (e.g., emotion and nurturing), male caregivers were comfortable providing care because they viewed their actions within the boundaries of a masculine framework that emphasized reason and rational calculation (Campbell & Carroll, 2007).

Our key informant from the CCAC recounted a situation that had been discussed at a recent international conference on caregiving. In a Scandinavian country there had been a construction strike at the same time that there was a homemaker shortage. To make the most of the opportunity, several communities re-directed unemployed male construction workers into caregiver jobs for elderly people. When the care recipients were asked afterwards about the quality of care that the male caregivers had provided, an elderly woman responded with “Great sandwiches!” This key informant emphasized the importance of continuing further research into the experience of male caregivers and acknowledged how little we really know about them.
Gender Issues for Employed Caregivers’ Recipients

1. More seniors, and particularly elderly women, are living alone and their employed caregivers may therefore require more flexibility and assistance in meeting their needs.

2. Women recipients are less likely to receive assistance than male recipients.

3. Some workplace policies have been shown to restrict employee access to benefits that may assist them in providing eldercare because they are based on the nature of their relationship to the care recipient.

It is important to note that as the Canadian population ages, better healthcare and increased longevity means that more and more senior men and women are living independently. This is a good thing. In 2006 there were more than 1 million people aged 80 years and over, and the number of centenarians, those aged 100 and over, rose sharply between 2001 and 2006. Two thirds of seniors aged 80 and over were women, and five out of 6 people over the age of 100 were also women (Martel and Caron-Malenfant, 2006).

It is also important to note that a significant number of older seniors are living alone, particularly seniors aged 85 and over. According to the 2002 GSS, 52% of women aged 65 and over and 18% of men 65 and over who received care lived alone (Cranswick, 2002). This is therefore an important issue, particularly for older women who need assistance and their employed caregivers. It is interesting to note that as recipients in need of care, whether they have chronic functional limitations or short-term needs after surgery, older women receive fewer hours of formal support than do older men. It is speculated that this occurs because women, and particularly those living alone, are often assumed to be more capable of performing household and personal care tasks than men under these same circumstances, mostly because care and self-care are in keeping with expected female gender roles (Morris, 2001). Therefore, the assumption is that women, given their apparent skills in the domestic sphere, will be better able to look after themselves than elderly men given the same need for care. This has implications for working caregivers who will need to assume significantly more care for senior women relatives/friends in the absence of community supports that assist others to remain independent.
As more people live longer and blended families increase, the definition of ‘family members’ in need of support is also changing. No longer does eldercare mean care for parents alone, but may also include elderly aunts, uncles, in-laws, step-parents, step-in-laws, and close family friends, as well as grandparents and great-grandparents (Fast & Keating, 2001; Martin-Matthews, 2006). Medjuck, Keefe et al. (1998) emphasize how restrictive workplace policies can be when they have clauses that deny leave or benefits to the employed caregiver based upon the employee’s relationship to the recipient in need. It is particularly interesting to consider that it is now not unlikely that a parent who is 65 or older and in need of care will also, in turn, be the caregiver of her own elderly parent, other relative or friend whose relationship may lie outside those sanctioned by policies and benefits. The employee who provides eldercare to her senior mother may also need to be prepared to assume or assist in the care for those relatives and friends who, in turn, depend upon her mother for assistance. This could include a disabled senior spouse who may or may not be the employee’s father or other disabled family members such as a sister or brother who live with or near the elderly parents. It could also include the employee’s elderly aunts, uncles or grandparents who may live nearby or far away, or her mother’s neighbours/friends who depend upon her for assistance. These observations highlight the networks of care that run in families, and among close friends – relationships that are often invisible to employers and policy makers (Fast, Keating, Otfinowski & Derksen, 2004; Federico, 2004).

C. Relating Gender, Work and Eldercare Issues to Practice

1. Work and family responsibilities are not separate, but are interrelated. By considering supportive solutions in the context of working caregivers’ lives, more appropriate workplace initiatives will be made available to support eldercare providers. But there are benefits for the workplace as well. Appropriate supports that enable workers to flexibly manage eldercare would encourage caregivers to remain in the workforce and should reduce costly rates of absenteeism, productivity loss, interruptions in services and errors in work that result from distraction and distress.

2. It is important to understand that women engage in the paid workforce for the same reasons as do men, and therefore assumptions about “natural” gender-specific choices may be erroneous and must be carefully scrutinized through gender analysis. When women (and men) take on caregiving roles because they feel they have no options or choices, the result can be especially stressful. Research shows that working women at
all occupational levels consider organizationally-based support for personal and family commitments as important to them. Policies should therefore be reviewed to identify contradictory goals and barriers that prevent employed eldercare providers from accessing supports, or being punished when they do so.

3. Women who work in rural areas and those who work as health and social service professionals in care professions may experience even greater difficulties when trying to meet the demands of both work and eldercare at the same time.

4. Caregiving needs and supports vary across and within regions. Assumptions that women will be available to care for seniors in particular regions may be erroneous. Employers should be aware that the services available to an employee in one region may not be available or accessible to employees in another region. Information on local supports and services needs to be accessible to all workers and, accordingly, policies need to be accessible and flexible where needed.

5. Men are less likely to discuss their eldercare responsibilities at work and may believe that their involvement as caregivers would be seen negatively. Workplace policies need to encourage and support male and female eldercare providers equally as a means of promoting good workplace mental health. Moreover, providing opportunities for men and women to learn about eldercare issues and services through on-line resources and to use flexible schedule and telework options when appropriate may be cost effective ways that organizations can assist caregivers, reduce the gender-based stigma associated with caregiving, and benefit the organization in the short and long-term.

6. As more seniors remain living independently in the community, the challenge of ensuring that health and social services meet growing demands will inevitably affect employees, particularly those who must provide eldercare in rural areas or at a distance. Since older women recipients tend to receive fewer hours of formal caregiving support, employed caregivers of female recipients may need to assume a greater role in providing care and experience a greater degree of caregiver burden for the care of elderly family members and their networks in the future.

7. As blended families create more distant and diverse family relationships, it will be increasingly important to widen the restrictions on who can receive care benefits to include extended family and close friends more broadly. Such efforts are in keeping with recent changes to policies related to compassionate care leave and benefits provisions and the Ontario Human Rights Commission’s efforts to highlight family status as a basis that should not be used in a discriminatory manner by employers.
2. The Needs of Employed Eldercare Providers and Their Workplaces

The needs of employed caregivers are dependent upon many factors both within and outside of the work environment and may change over time. As the workforce ages and more employees have eldercare responsibilities, more workplaces and departments within workplaces will have to address the needs of this population. Ultimately, the extent to which individuals are supported in the workplace will have repercussions for themselves as workers, for the senior(s) they are caring for, and for their workplace.

A. What Do We Know Already?

1. A proportion of employed eldercare providers experience considerable amounts of stress and caregiver strain -- factors that affect their productivity and well-being.

2. Eldercare providers make a variety of work adjustments to help manage work and eldercare responsibilities.

3. Caregivers have higher rates of absenteeism that are reflected in direct organizational costs. Organizations need to find a way to lower the rates of absenteeism and rising health care benefit costs.

4. The retention of good employees who are forced to quit in order to meet the demands of family caregiving is an issue that continues to grow. As many as 10% of recent retirees said they retired when they did, in part, to provide eldercare. Among workers aged 45-64 in 2002, 1 in 5 women and 1 in 10 men said caregiving would be a likely reason for their retirement.

5. Many caregivers report that they had to change holiday plans and alter their routine social activities in order to provide care, sacrificing opportunities that would have given them much needed stress relief. Having a break from caregiving is an important unmet need for many caregivers.

6. A significant proportion of caregivers lose sleep as a consequence of providing eldercare and this can be a safety issue at work. Therefore employees may need flexibility in scheduling and hours of work for this reason, as well as others.

7. The top four needs that employed caregivers have identified include: respite/relief, financial compensation, information on long-term illness and caregiving, and flexible working arrangements.

8. Informal support provided by managers and co-workers can be as, or more important than formal workplace policies and practices. Many caregivers experience unpredictable situations that require their immediate presence.
While many employees can effectively manage work and care responsibilities reasonably well, some experience considerable difficulty - particularly when caregiving demands increase and they have few supports. Duxbury and Higgins (2005) estimated that one in four employed eldercare providers experience high levels of caregiver strain -- particularly those providing more hours of care and having primary responsibility for eldercare.

According to Fast and Keating (2001), more than half of employed Canadian caregivers made adjustments to their employment to provide care, costing them more than $1.2 million in lost current and future income. The ways in which caregiving responsibilities affect respondents’ employment include missing full or part days of work, postponement of educational and employment opportunities, and being forced to use sick days, vacation and personal leave in order to fulfill eldercare tasks (Fast & Keating, 2001). As described earlier, the most common work adjustments include changed work patterns and reduced work hours, both of which are far more common for women than men caregivers (see Figure 3).

Employees’ needs and options reflect the caregiving situations and demands they are dealing with (which often change over time, and can be unpredictable) and the extent to which they are able to take advantage of alternative work arrangements (flexible scheduling, work at home, time banking, etc.) on either a formal or informal basis. In the absence of the financial resources to do otherwise, employees must provide the care that is needed for their elderly loved one themselves, and because eldercare can sometimes be more episodic and crisis driven than childcare, the need to be absent from work is not always predictable (de Wolff, 2003; Higgins & Duxbury, 2002). This can add to increasing business concerns over the high cost of employee absences.

It is estimated that absenteeism due to work-family conflict that includes eldercare costs Canadian firms approximately $3 billion per year (Brink, 2004; Duxbury, Higgins & Johnson, 1999). Research clearly shows that organizations that create a culture of overwork, including long hours of work and a high number of hours of unpaid overtime, contribute directly to employee role overload and work-family conflict (Duxbury & Higgins, 2005). In turn, these effects have been well documented as directly contributing to workplace stress, poorer mental health, absenteeism, reduced job
commitment and intentions to leave (Higgins, Duxbury & Johnson, 2004). As the demand to address family needs spills into the workplace, time spent on the phone at work and time one is distracted or preoccupied with eldercare concerns can also be counted as partial “absenteeism” even though it takes place at work. Additional invisible costs pertain to the added stress co-workers may experience, especially as their own workload or performance is affected by a colleague or team member’s difficulties in meeting unadjusted work demands or stress in trying to find or arrange home care, or other services.

In 2006, the Commerce Clearing House (CCH) conducted a survey of 326 Human Resource executives in U.S. companies and organizations across major industry segments in 47 states in an attempt to identify what they saw as the most effective programs for keeping healthy workers on the job. This survey was undertaken because by 2006 the rate of unscheduled absenteeism in the U.S. had climbed to its highest level since 1999, costing some large employers an estimated $850,000 per year in direct payroll costs, and even more when lost productivity, morale and temporary labour costs were considered (Commerce Clearing House, 2006). Similar to the Canadian research findings, the results of the CCH survey showed that U.S. managers reported that low morale among employees was associated with higher absenteeism rates; a finding that is also reflected in research from the employee perspective (Commerce Clearing House, 2006; Hughes, Lowe et al., 2003).

It was also interesting to note that when U.S. managers were asked to rank the effectiveness of a variety of work/life programs in controlling or reducing employee absences, they often ranked the programs that were offered least often as those that were most effective – suggesting that many may be wasting their resources on programs that are not as appropriate or effective in achieving this goal (HR Focus, 2000). Specifically, managers ranked alternative work arrangements as the most effective program for reducing absenteeism, but only 63% of organizations provided this as an option for their employees (Commerce Clearing House, 2006). Managers also rated “Buy Back” programs, where the employer “buys back” in cash or vacation time all or some of the employee’s unused sick time, as highly effective in preventing absenteeism, but only 59% of them offered this option to employees (Commerce Clearing House, 2006).
contrast, disciplinary action was an absence control strategy used by 97% of the managers sampled, but was not ranked highly as being effective in achieving this goal (Commerce Clearing House, 2006).

Data from Statistics Canada’s 2002 General Social Survey revealed that 14.3% of women and 6% of men aged 45 years and older who had retired did so, in part, to provide eldercare. Six percent of the people who retired between 1992 and 2002 stated that they would have continued working if suitable arrangements for caregiving had been available to them (Statistics Canada, 2004). In his address to highlight the need for changes to family medical leave legislation, the Ontario Minister of Labour cited even more alarming statistics when he noted that “…more than 40 per cent of employees caring for a seriously ill family member have had to quit their job. One quarter of them lost all or most of their savings” (Ontario Ministry of Labour, 2004). Moreover, in an analysis of the Canadian National Survey of Ageing and Independence, McDonald, Donahue and Moore (1998) found that compared to other retirees, employees who retired because of caregiving duties were more likely to be female, to be on the margins of the economy with lower personal incomes, and were less likely to receive benefits from the public or private pension systems or to have income from investments.

In its 2002 study of Canadian caregivers, Decima found a number of specific forms of work-related support that caregivers identified could help them with their family care responsibilities. These included flexible work hours and short-term leave with job and income protection. The lowest rated benefits were those related to leave of absence without pay which, given the additional financial burdens often associated with eldercare, could add additional stress for employees (Decima, 2002). Flexible work hours may be particularly helpful for those employees who provide more intensive eldercare, as lack of sleep is often reported to be a problem that can spill over into work (Macbride-King 1999). This is particularly problematic for employees who care for seniors with cognitive difficulties including Alzheimer’s Disease (Alzheimer Society n.d.; Decima, 2004). Access to flexible scheduling where employees can choose their number of hours and days of work has consistently been one of the top needs identified by employed caregivers (Lowe, 2005; Macbride-King, 1999; Pyper, 2006), and would be particularly useful to those who suffer from sleep deprivation. American research by Shoptaugh,
Phelps et al. (2005) found that employees were less likely to be late for work, leave early, be interrupted while on the job, or consider leaving their job if they had control over their schedules. In addition, employees reported greater levels of job satisfaction and commitment to the organization when they had control.

Caregivers also report that their responsibilities often result in their needing to sacrifice leisure and vacation time, activities that could provide some stress relief for them (Dunn & Strain, 2001; Fast & Keating, 2001). Yet, American researchers found that engaging in personal interests and family time actually enhanced work effectiveness for women executives, suggesting that organizations have something to gain by encouraging families to use vacation and leisure time as it is intended (Ruderman, Ohlott, Panzer & King, 2002).

Among Canadian women caregivers who worked longer hours, 8 in 10 indicated that obtaining some relief/respite from their responsibilities would be very helpful to them (Pyper, 2006). Moreover, caregivers note that respite is important particularly for employees of the “sandwich generation” who are providing care to elderly people and children at the same time (Habtu & Popovic, 2006). Sandwich generation employees with dual caregiving responsibilities are more likely to consider leaving their current employer because of work/family conflicts than other employees who quit and this has implications for the retention of valuable workers (Macbride-King, 1999).

Many employers are facing difficulties in finding and retaining workers, particularly as the baby boom generation moves closer to retirement (Hughes, Lowe et al., 2003). Employee retention is associated with the availability of good family-friendly benefits and a workplace culture that supports their use as appropriate, particularly for university educated employees (Hughes, Lowe et al. 2003).
B. Emerging Themes on the Needs of Employed Eldercare Providers and Their Workplaces

Employed Eldercare Providers

1. Employed eldercare providers need to be able to connect with agencies and support networks both within and outside of traditional working hours.
2. Changes in rural communities have implications for employed caregivers who live in urban and rural areas.
3. The needs of employees who live in, or provide care to seniors who live in rural areas may be different than those of their urban counterparts.
4. Many employed caregivers need financial support to offset the high cost of caregiving. Government-based financial compensation initiatives for employed caregivers are under critical review.
5. Some caregivers are retiring from the workforce earlier than expected in order to provide eldercare.
6. The needs of eldercare providers in the military are becoming an issue, as more Canadians are being deployed overseas.
7. Public policies do not reflect the needs of eldercare providers and should be reviewed.

In a report about combining employment with caring for elderly people in the United Kingdom, it was suggested that employed caregivers are less likely than non-employed caregivers to be involved in the hospital discharge process of their loved one because they were unable to attend meetings or assessments during working hours (Pickard, 2003). One of our key informants, PC, who is both a professional in the geriatric mental health sector and also an eldercare provider for both her own parents and her in-laws, is aware of this problem from both sides. She acknowledges that ‘client-focused’ practice is the buzzword and a goal in health services today. However ‘client-focused’ services for employed caregivers sometimes miss their mark when agency staff are unwilling or unable to adjust their own schedules to meet the needs of family members who are working and can not come for meetings or care conferences during the day. In PC’s experience, there are some service agencies and health care practitioners that are very strict and will not accommodate the after-hour needs of working caregivers. This means that employees sometimes have to take time off without pay to attend
elderly-care-related meetings or have to forego attending. PC suggests that the health care system needs to be challenged with respect to the needs of working caregivers and some accommodations made. At the same time, employers could provide employees with some flexibility to enable them to be present for doctor’s visits, discharge planning and transitions (to and from hospital, from independent living to assisted living, etc.). PC notes that some caregivers may not be able to be present to provide care, but they are still very interested in providing support and managing care from a distance. It is important to acknowledge that caregivers may need to engage with the system in different ways (from close by and/or far away) and that agencies and workplaces need to work in partnership to support employed caregivers in their need for flexibility for attending to family demands.

Our key informant, Dr. G. supports this view stating that:

“Caregivers often aren’t in touch with the family member until after they finish work. They can’t get the time off work. That’s a huge issue and that’s an issue certainly in our facility - we’re trying to put family ahead in the sequence. It’s an extra pressure for them. They don’t want to be taking the time off work. In some cases they’re going to lose financially and in a situation where it is already financially tough, they take a half a day off work to come in with us to find out about issues around care…Obviously this is an issue, so sometimes it’s harder to get them in….”

Research suggests that those providing care to seniors from a distance may be particularly at risk for high level stress. They may also experience even more difficulty trying to connect to agencies who can facilitate care for their loved ones, particularly if they are in a different time zone or country (Joseph, Leach & Turner, 2007; Shellenbarger, 2004). Furthermore, a key informant from the Canadian Alzheimer Society emphasizes that the type of workplace that a caregiver works in, and the job she/he does, can cause problems for arranging long distance care by telephone. For example, women or men who work at a desk with the internet and a telephone may be more fortunate, while those working in restaurants or on assembly lines are the least fortunate because they would not have access to the resources, or flexible time during working hours, to connect with agencies or other support people. This again suggests that both workplaces and social service agencies may need to work together to find more
appropriate ways to support employed caregivers, particularly those who work in sectors where care management during working/service hours is difficult or impossible.

Among those sectors where employees face significant challenges associated with providing long distance eldercare is the military. U.S. studies note that this lifestyle, with its frequent moves, restricted housing and overseas postings, makes it extremely difficult for men and women who work in the military to provide eldercare at a distance or face-to-face (Parker, Call, Dunkle and Vaitkus, 2002; Parker, Fuller, Koenig, Vaitkus, Bellis, Barko, Eitzen & Call, 2001). Although research in the area of care for elderly veterans is growing, there are few Canadian studies that explore the experience of the military caregiver. Military research on families in Canada has predominantly focused on domestic violence and family difficulties following deployment related to post-traumatic stress. However, several studies have been related to Canadian veterans (Pedlar, Conrad & Gallant, 1999; Statistics Canada, 1998; Veterans Affairs Canada, 1994; Keating, Eales & Fast, 2001), and one recent study shows that Veteran’s Affairs policies are having differential financial impacts on informal caregivers (Fast, Eales et al., 2001). As Canada continues to deploy troops both across North America and abroad, it is increasingly important to understand how Canadian military workers engage in providing eldercare and how this experience, coupled with their lifestyle and location, impacts upon them and their care recipients at home.

Canadian research shows that for employed caregivers who must travel back and forth to provide care and support over sometimes significant distances, additional time burdens are created along with increased risks that can affect both safety and health, particularly when driving under stress (Joseph, Leach & Turner, 2007). U.S. studies report that 15% of family caregivers travel an average of 450 miles (up to 8 hours driving) to provide care to family members (Smith, 2006; MetLife Mature Market Institute, 2004).

With recent changes to the health care system, particularly with early discharges from hospitals and the move to providing more care in the home, the costs to caregivers of providing informal eldercare has been labeled as a “hidden cost” of the health care system (Macbride-King, 1999). Our key informant from the Ontario Community Care Access Centres points out that the general population understands very quickly when
their local hospital is in trouble or when their emergency room is overcrowded, but when you have caregivers burning out in the community it is not something that people are generally aware of or see as a crisis.

One component of caregiver stress is the financial burden that often results from extra expenses incurred due to caregiving in addition to possible loss of income from reducing work hours or taking unpaid leave (Cranswick, 2002; Habtu & Popovic, 2006). Our key informant from the CCAC emphasizes the fact that support programs tend to be focused on the senior in need and not on the caregiver; yet, most programs for recipients of care have the potential to generate out of pocket costs for informal caregivers, and user fees and low ceilings on means tests make services less affordable to seniors with limited incomes – who must then depend upon their loved ones (i.e. employed caregivers) for financial support to obtain assistance or hands-on support if services are not affordable to families (Fast, Eales et al., 2001). Out of pocket costs borne by care providers reported in Decima’s 2002 survey included transportation, nonprescription medications, medical supplies, prescription medications and other equipment. Four in ten caregivers reported spending between $100 and $300 per month on such expenses, with another quarter (24%) spending in excess of $300 per month.

Costs associated with home care, respite care and emergency care can be particularly high (de Wolff, 2003). Eldercare providers may also incur lost current and future income, lost employment benefits, out-of-pocket expenditures that include renovation and disability accommodation as well as the effects of their unpaid labour contribution on pensions, sick time and vacation (Fast, Eales et al., 2001). In particular, Pitrou (2005) asserts that the current pension system does not match the needs or the reality of Canadian women (caregivers) today. Women’s lives may be typified by multiple transitions in and out of the workforce, including time spent in temporary or short-term jobs, or in self-employment, as well as time when they are not in the paid labour force because they are caring for children, seniors, or other family members. Such irregular work patterns do not match the current pension system with its emphasis on job tenure and life-long careers. Pitrou (2005) states that the pension system today not only excludes many Canadians, but it does not recognize the burden of institutionalized lower
salaries for women or the costs to them personally and economically because of their unpaid work.

Caregivers are present in all income levels, but tend to have household incomes below the national average. Only one in three caregivers (35%) report household incomes of $45,000 or more (Decima, 2002). Yet the impacts of eldercare on financial well-being are much broader than just incurring expenses on behalf of the recipient. For example, when caregivers take a leave of absence or leave the workforce to care for a senior, their pension earnings are affected (Smith, 2004). The Canada Pension Plan (CPP) income is based upon the amount contributed to the plan and the length of time that an individual makes a contribution (Fast, Eales et al., 2001). If paid employment is terminated, then both the amount and length of time contributed is reduced. For those who are raising children, there is a 7 year “drop-out” provision that does not penalize an employee. However, the provision does not count eldercare as pensionable time (Walker, 2005). Research shows that low income during working years is a significant predictor of poverty in old age, and Fast, Eales et al. (2001) suggest that social assistance and CPP policies, in ignoring the responsibilities of caregivers, may be contributing to the poverty of older women in Canada.

A Decima study (2002) found that 42 percent of their sample of caregivers expressed a desire for short-term job and income protection through the federal government’s Employment Insurance program. Fewer than 18% said that it would be helpful to have access to a family related leave of absence without pay – most likely because they could not manage without employment income (Decima, 2002).

A relatively new financial benefit for employed caregivers introduced by the federal government in 2004 called the “Compassionate Care Benefit” is a landmark policy initiative launched through the Employment Insurance Program to assist working caregivers to take time off work to care for a terminally ill family member by providing them with economic support. Federal and provincial legislation (in most provinces) provides Canadian employees with the right to take job-protected leave for 8 weeks for this purpose while the Compassionate Care benefits provide 6 weeks of partial income replacement. Evaluation studies, however, indicate that the uptake of the benefit has been much lower than expected and there has been significant criticism over who
qualifies for the financial support (Osborne & Margo, 2005). For example, every employee who pays regular Employment Insurance premiums is able to apply for the benefit. However, while the compassionate care benefit itself is federally regulated, Table 3 shows that not all employers in every province are required to grant a leave of absence under the same conditions for their employees because leave is regulated through provincial labour standards. Employees who must quit work in order to take a leave may still be eligible for the compassionate care benefit, but not for other EI payments or employment tax credits that would be available to those who remain in the workforce (Service Canada – personal communication). In 2006, Alberta and the Northwest Territories were two Canadian jurisdictions that left the granting of a leave for compassionate care to the discretion of the employer (AON Consulting, 2006).

Table 3: Compassionate Care Leave Provisions Across Canada

<table>
<thead>
<tr>
<th></th>
<th>Qualifying Period</th>
<th>Maximum Length of Leave</th>
<th>Benefit Coverage During Leave</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federal</td>
<td>None</td>
<td>8 weeks</td>
<td>Yes</td>
</tr>
<tr>
<td>British Columbia</td>
<td>None</td>
<td>8 weeks*</td>
<td>Yes</td>
</tr>
<tr>
<td>Alberta</td>
<td>Not specific under legislation, at the employer’s discretion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Saskatchewan</td>
<td>13 weeks</td>
<td>16 weeks</td>
<td>Employees must be given option to maintain benefits at own expense</td>
</tr>
<tr>
<td>Manitoba</td>
<td>30 days</td>
<td>8 weeks</td>
<td>Not specified</td>
</tr>
<tr>
<td>Ontario</td>
<td>None</td>
<td>8 weeks</td>
<td>Yes</td>
</tr>
<tr>
<td>Quebec</td>
<td>3 months</td>
<td>12 weeks for family member</td>
<td>104 weeks for minor child</td>
</tr>
<tr>
<td>New Brunswick</td>
<td>None</td>
<td>8 weeks</td>
<td>Not specified</td>
</tr>
<tr>
<td>Nova Scotia</td>
<td>3 months</td>
<td>8 weeks</td>
<td>Employees must be given option to maintain benefits at own expense</td>
</tr>
<tr>
<td>Prince Edward Island</td>
<td>None</td>
<td>8 weeks</td>
<td>Not specified</td>
</tr>
<tr>
<td>Newfoundland &amp; Labrador</td>
<td>30 days</td>
<td>8 weeks</td>
<td>No</td>
</tr>
<tr>
<td>Yukon</td>
<td>None</td>
<td>8 WEEKS</td>
<td>Not specified</td>
</tr>
<tr>
<td>Northwest Territories</td>
<td>Not specified under legislation, at the employer’s discretion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nunavut</td>
<td>None</td>
<td>8 weeks</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Some provinces provide longer periods for unpaid compassionate care leave with Saskatchewan granting 16 weeks and Quebec providing 12 weeks for a gravely ill family member and 104 weeks for a terminally ill child (AON Consulting, 2006). Nevertheless, while most provinces now require employers to grant 8 weeks of compassionate leave, they differ in their definition of what constitutes a “family member” and in the requirement that employers need to cover employees’ benefits while they are on leave, with many provinces leaving it to the discretion of the employer (AON Consulting, 2006; Nova Scotia Environment and Labour, 2007; Zhang, 2007). Of note is the fact that the federal compassionate care benefit is not available to caregivers who are self-employed and may not be available to those who work part-time. Finally and importantly, employees can only qualify for compassionate care leave and benefits if the care recipient can be certified by a physician to be near death. This ignores the common need for support for caregivers of seniors who are chronically ill over longer time periods or who require non-life threatening surgery to maintain their health and capacities (AON Consulting 2006; Osborne & Margo, 2005; Service Canada Personal Communication).

The Canada Labour Code provides an allowance for 5 paid days of family leaves, but this only applies to federally regulated industries and federal employees (McCloskey, 2005). In other provinces employees are at risk of losing their jobs and/or their benefits if they take a leave of absence of several days or a few weeks to provide care to an ailing family member (Fast, Eales et al., 2001; McCloskey, 2005). If leave is not an option, working reduced hours is often necessary. In 2002 about 10 percent of 55-64 year olds who were caregivers cut down on the amount of time they spent on paid work (Cranswick, 2002). Moreover, 2 percent of caregivers 45-64 years old reported that they stopped working altogether in order to provide care (Cranswick, 2002). For some caregivers, however, particularly those providing end-of-life care, research shows that employment (being employed) may actually help caregivers to cope with the psychological burdens of providing informal palliative care (Fast, Eales, et al., 2002). Therefore, supporting an employee’s need to combine the demands of paid work and care responsibilities will not only allow them to provide care longer with fewer dire
consequences, or care for a week or two to provide extra care and support related to a hospitalization will also keep valuable employees in the labour force and contributing to the tax base (Fast, Eales et al., 2002).

The federal government also provides several tax credits that are available to caregivers. These credits include the caregiver tax credit, the disability tax credit, the eligible dependent tax credit and the medical expenses tax credit (McCloskey, 2005). While these tax-based benefits appear fairly generous, few caregivers receive significant financial compensation from them for several reasons. Non-refundable tax credits are often means tested and eligibility such as co-residence or close kin relationships disqualify many who need this support (McCloskey, 2005). Furthermore, the complexity of the eligibility criteria and the calculations involved in applying for these tax credits creates barriers for many (McCloskey, 2005).

One of our key informants, Dr. P (Professor) suggests that the changes to mandatory retirement policy that have recently occurred in Ontario and in some other provinces, may create a unique scenario with respect to the possibility that some middle aged employees may soon have to provide care to their employed parents. Because elderly parents may have gone through a different retirement experience than the way people are retiring now, Dr. P suggests that for employed caregivers, retirement decisions and what elderly parents look like in terms of their work, their housing, their income, and their leisure may keep changing. Clearly, the impact of this new legislation is an issue that requires further study.

Culturally Diverse Employed Eldercare Providers

1. The needs of immigrant caregivers are met in some provinces, but not others, and for some immigrants, but not for others.

2. Health problems and illness concerns are often not effectively communicated by immigrant caregivers because of language barriers. Moreover, information about access to services may be problematic because of this.

3. Culturally diverse caregivers fall through the cracks when trying to access services that are available to them because of a lack of coordination between Federal and Provincial jurisdictions.

4. The needs of those with alternative lifestyles and sexual orientations are also often overlooked.
5. Immigrant caregivers are not always able to meet their financial commitments because of policy barriers that keep them at a financial disadvantage as newcomers for significant periods of time.

6. The needs of First Nations seniors and their caregivers are also unique.

Canada is well known in the global community as a multicultural society (Stewart, Neufeld, Harrison, Spitzer, Hughes & Makwarimba, 2006). In 2001 the Canadian Census listed 113 ethnic groups which currently make up 18% of the population (Denton & Kusch, 2006). However, it is predicted that under the scenarios considered for population projections, Canada will have between 6.3 million and 8.5 million immigrants who are members of visible minorities by 2017 (Statistics Canada, 2005b; Stewart, Neufeld et al., 2006). It is interesting to note that as of 2001, over 26% of the population of Ontario was foreign-born, with over 10.5% of the population in British Columbia, Alberta, Manitoba and the Yukon territory also made up of foreign-born people (Statistics Canada, 2001b). While the largest and still growing visible minority groups include Chinese and South Asians, newcomers to Canada also include Blacks, Filipinos, Latin Americans, Arabs, West Asians, Japanese and Koreans - providing Canadians with a rich tapestry of cultural practice, perspective and influence (Statistics Canada, 2005). It is also important to point out that the immigrant populations are spread across Canada in regions that differ vastly in their economic and social composition, needs, and resources (Keefe 1997; Statistics Canada, 2001a). Globally, more than 50% of all international migrants are women and 18% of immigrants to Canada are seniors (Denton & Kusch, 2006; Stewart, Neufeld et al., 2006).

While employed caregivers may suffer economic, social and health-related hardships when providing eldercare, these risks are increased for older immigrants and their caregivers, particularly if they have language/communication difficulties, challenges accessing information and services, health practices that vary from Canadian standards (Leung, 2000), and if employed caregivers and/or their recipients of care are forced by immigration residency policy into economic dependency without access to health services, homecare and old age security for significant periods of time (Denton & Kusch, 2006; Ho, Friedland, Rappolt and Noh, 2003; Stewart, Neufeld et al., 2006). Although researchers have noted a “healthy immigrant effect” that suggests that recent
arrivals enjoy better health than their Canadian-born counterparts, older immigrants have significantly poorer health (Gee, Kobayashi and Pruss, 2004 in Denton and Kusch, 2006). A further complication is that health care coverage varies between provinces and has restrictions based upon immigrant status (Stewart, Neufeld et al., 2006). These economic and social barriers affect the well-being of aging immigrants and their caregivers. Because of this, caregivers’ well-being represents a growing concern particularly for aging immigrant communities.

Keefe (1997) points out that there are distinct characteristics within different regions of the country that reflect, among other things, changing migration factors and immigration settlement trends. As noted earlier, the risk for caregivers in this context is that national policies based on “the average Canadian” will fail to be sensitive to the distinctive characteristics that exist in different regions, rendering services and supports either inappropriate to meet the needs of some immigrant groups over others or lack of programming altogether. There is a risk for caregivers that policies and services will be applied to all ethnic groups the same way, ignoring cultural differences and regional disparities (Denton & Kusch, 2006; Ho, Friedland, et al., 2003). Moreover there is a fear that ‘blanket’ policies will be based upon cultural assumptions that are, in fact, erroneous. For example, it appears that, in general, East Indian immigrants tend to live in multi-generational households. However, researchers point out that this may be less a cultural preference than a reflection of limited economic resources (Armstrong & Kits, 2001). Chinese, Greek and Italian elderly people are also less likely to live alone. However, this too may not represent a cultural value of proximate caregiving as much as a reflection of low incomes, lack of pensions and policy-induced economic dependency on others (Armstrong & Kits, 2001).

Language barriers can limit caregivers’ and care recipients’ access to health and social services, particularly in times of crisis (Chew-Graham et al., 2002 in Stewart, Neufeld et al., 2006). It has been noted that Canadian immigration policies offer more limited access to language programs for women than men, since men are usually the skilled employable applicant among newcomer families. Moreover, immigrant women in most cultures may have little spare time to attend language classes because of caregiving or other domestic responsibilities in addition to employment (Stewart, Neufeld et al.,
Unfortunately, language and cultural misunderstanding can discourage immigrant caregivers from seeking help when needed (Leung, 2000; Boyd, 1997 in Stewart, Neufeld et al., 2006).

Ho, Friedland, et al. (2003) note that a sense of cultural obligation to assume the care of a loved one acts as a coping mechanism for some Chinese caregivers, thus potentially increasing time demands and putting them at risk when they do not ask for help when it is needed. Unfortunately, caring responsibilities, the lack of subsidized home care, transportation difficulties and the marginalized employment opportunities that many immigrants face can result in little money and no time to persevere with language programs (Stewart, Neufeld et al., 2006). In addition, work status and associated earnings impact upon caregivers’ ability to pay for private language or health support services such as respite care necessary for caregivers to attend language classes (Stewart, Neufeld et al., 2006).

The limited number of foreign-trained professionals, particularly in the health care sector, also increases the risk that health and illness concerns and health information will not be communicated by either party effectively. Immigrant caregivers suggest that brochures and information available in their own languages would help them to become more aware of programs and services that can support their needs and reduce the chance of putting care recipients’ or their own health at risk. Moreover, Chinese Canadians reported that service and support groups facilitated by Chinese organizations can help newcomers make the transition to understanding Canadian culture and become informed about the support that is available to them (Ho, Friedland et al., 2003).

It has been suggested that the federally run Canada’s Settlement Services Program has been eroded in the last few years through economic restructuring that has resulted in diminishing supports for new immigrants and immigrant caregivers (Stewart, Neufeld et al., 2006). The program’s focus on new immigrants means that there are often insufficient resources available to assist women who have caregiving needs that develop later on or over a longer period of time. In addition, families who sponsor immigrants through the Family Reunification Program must assume financial responsibility for them for a period of 10 years – rendering many caregivers and recipients of care dependent upon others for their economic security. Those who are sponsored through this program
are not able to access many publicly funded programs such as income security (including basic Old Age Security), hospitalization and homecare, which places a significant burden upon immigrant caregivers who are supporting newcomers, or immigrants who are sponsoring caregivers who care for a number of recipients from different generations (Stewart, Neufeld et al., 2006).

Coupled with these risks is the difficulty of sorting out Federal and Provincial jurisdictional requirements and eligibility criteria when seeking services or supports that may exist to help immigrant caregivers lighten their burden. While Settlement Services and other immigration policies are the responsibility of the Federal government, health and social services are provincially run – with some ethno-specific organizations providing services at the local level as well. Few of these services are well coordinated intersectorally and the inflexibility of rules and regulations has been noted as a challenge for immigrant care providers (Stewart, Neufeld et al., 2006).

It has been shown that caregivers of Asian, East Indian and Southern European origins provide greater amounts of assistance to their elderly kin than do British and other caregivers (Keefe, Rosenthal & Beland, 2000). Dr. G. (a geriatrician) confirmed that this is the case in her experience, and that non-British women may have even more pressure to assume the care of elderly family members. Indeed in some cultures, a family member’s lack of rights to choose NOT to care, or to be able to share the care with other family members, may cause additional stress in attempting to balance work and family demands that can be overlooked by employers.

In addition to the challenges that employed immigrant caregivers face when they try to provide eldercare within Canada, are challenges that are compounded for them if they also have responsibility for caring for a senior who lives outside the country. As mentioned earlier, long distance eldercare presents many challenges for the employed caregiver, but when the care recipient lives in another country or even on another continent, the difficulties in providing long distance eldercare are exacerbated.

A static view of culture that ignores individual differences, cultural norms, religious practices and stereotypes poses danger and difficulties when creating policy (Dorazio-Migliore, Migliore & Anderson, 2005). To ignore the impact of power and
politics in medical encounters is to overlook significant barriers to the health of elderly family members and in the lives of caregivers who are culturally diverse. Nevertheless, it is not only immigrant Canadians who can fall through the caregiving policy cracks. First Nations seniors and their caregivers have beliefs and needs that are often overlooked as well (Parrack & Joseph, submitted). For Aboriginal peoples, the definition of “elder” itself is different from what is commonly understood in other parts of the country. Furthermore there are many Aboriginal cultures with unique languages and cultural practices in Canada, where there are 11 Aboriginal language groups, made up of more than 65 distinct languages and dialects. Over 12% of Aboriginal seniors over the age of 65 speak neither English nor French (Health Canada 1998). Since the life expectancy for Aboriginal people is lower than the life expectancy of Canadians in general, someone as young as 50 years of age could be viewed as ‘elderly’ by family and community members (Durst, 2005). In some Aboriginal communities, barriers to service and support include language problems, lack of cultural competence among health care providers, problems of transportation, communication, and service delivery in remote communities promote institutional discrimination that can impact not only upon Aboriginal seniors, but also upon their relatives who are trying to combine work and family demands to care for them (Ellerby, McKenzie, McKay, Gariepy & Kaufert, 2000).

While many employed eldercare providers may feel isolated, for those whose lifestyles are marginalized in our society, the experience of providing eldercare may be even more complex. Lesbians and gays not only experience additional stress as caregivers, they also experience more barriers in the face of hostility and discrimination on the part of benefit plans and formal care providers (Morris, 2001). Yet little is known about this group who may have greater difficulties balancing the demands of work and eldercare as a result. Because gays and lesbians are sometimes rejected by their families and others, it has been shown that they often develop more friendships than their heterosexual counterparts (Lipman, 1986 in Brotman, Ryan & Cormier, 2006). These friends serve as “family” members for gays and lesbians and are the most important sources of support, both for care provision and accompaniment/advocacy for them in the health care system (Lipman, 1986 in Brotman, Ryan et al., 2006). It is therefore
important to ensure that these family members are not excluded from institutional family-friendly policies.

Morris (2001) notes that there are major gaps in the caregiving research and a lack of studies on marginalized groups such as gays, Aboriginal peoples and those who are caregiving in northern and remote provinces or territories. Clearly more research needs to explore the context of these Canadians.

Understanding Workplace Needs

No review of work and eldercare is complete without considering what is needed within the workplace in order to support employees who are providing eldercare.

1. Employers and organizations want to find ways to bring down the cost of absenteeism, early retirement, and reduced work load for employees who are caring for a parent with significant health problems.

2. Employee retention is a growing issue that organizations identify as needing to be addressed.

3. Managers and supervisors report that they need skills, tools, time and incentives to manage and focus on the ‘people’ part of their jobs.

4. In order to successfully introduce and sustain flexible work arrangements, organizations may need to introduce new performance measures that focus on objectives, results and output (instead of focusing on hours and presence) and reduce undesirable impacts on work teams.

5. Research on employed caregivers has shown that organizations need to clearly communicate what benefits are offered and to whom, and they must avoid stereotyping based solely on age and generation.

Shoptaugh, Phelps et al. (2004) highlight the fact that there are risks associated with employers intruding into employees’ non-work lives, and that organizational leaders have not received adequate guidance on the direction that such interventions should take. This is thought to be one of the reasons why American business has been slow to adopt programs in support of employees who provide eldercare. Yet the cost to business of ignoring the problem is increasingly evident. In 1997, MetLife Mature Market Institute and the National Alliance for Caregivers estimated that the aggregate cost in lost
productivity to U.S. businesses associated with employees caring for the elderly was between $11 and $29 billion annually. The cost to organizations when an employee must quit work in order to provide care is equally significant. In a Decima (2002) study, more than one quarter of Canadian caregivers quit, retired or experienced other job changes as a result of their care responsibilities. Messing (2005) suggests that workplace interventions aimed at preventing work termination as a coping strategy should concentrate on improving the work environment rather than focusing on coping skills. Just as the law requires that workplaces must ensure the health and safety of workers in areas such as water, food, breaks and bathrooms, Messing (2005) asserts that accommodating family responsibilities must also be included in official workplace standards and employment policies (Messing, 2005).

Our key informant, Dr. P suggests that sadly, young women who are interested in cultivating professional careers may forego having children if the issues of work/family balance are not resolved. Moreover, this, he points out, will also reduce the number of people and family members available to care for our elderly, right at a time when the number of elderly people in society is increasing. This should be of concern to employers who may find that caregivers without siblings or children will more often need to assume sole responsibility for the care of an elderly parent or relative and may need significant accommodation from the workplace to do so.

Experts suggest that in order to meet the needs of employed caregivers while benefiting the organization at the same time, employers should develop strategies that will help them focus on changing the workplace culture. For example, Duxbury, Higgins & Coghill (2003) recommend that employers improve their “people management” practices within their organizations. Managers and supervisors need to learn new skills such as communication, conflict resolution, time management and project planning skills in order to respond to the changing needs of the workplace. In addition, managers also need the tools, such as appropriate policies, developing a business case, training on implementing alternative work arrangements, and resources on how to handle different HR problems in order to manage people more effectively. None of these strategies will be effective if managers are not provided with the time and resources they need to manage this as a fundamental part of their job, with incentives such as feedback, rewards
and promotion to reinforce the importance of acquiring these ‘people skills’ (Duxbury, Higgins & Coghill, 2003). When employers are focused on hours rather than output, and on presence rather than performance, change will not occur. Organizations need to find new ways to measure performance that includes rewarding output instead of hours and focusing on what, not where work is done (Duxbury, Higgins & Coghill, 2003). Research on the effective implementation of alternative work arrangements should be made more widely available and adapted as required.

As noted earlier, work and eldercare are not separate spheres, but are integrated, with each realm having a significant impact upon the other. In 1994 the Canadian Aging Research Network (CARNET), whose research headquarters were housed at the University of Guelph, held a Roundtable on the topic of “Eldercare and the Workplace: The Role of Business, Labour and Government”. At that time, business leaders argued that economic constraints were such that employer-initiated eldercare and flexible work arrangements for caregivers were not high priority issues for them. It was suggested by business leaders at that time that employees and the community may have unrealistic expectations of organizations in their capacity to meet the needs of employees who were also providing eldercare. However, the emerging research and changing demographic conditions that are resulting in increasing concerns about recruiting and retaining skilled workers in a competitive economy and enhancing productivity in a tight labour market suggest that times are changing. Indeed, supporting employees as they seek to combine the demands of work and family shows benefits for both workers and the workplace.

C. Relating Employee and Workplace Needs to Practice

1. Health and service sector workplaces are well suited to facilitate innovative strategies to assist employed eldercare providers to access services both inside and outside of traditional working hours and to develop innovative strategies and information resources to assist employed eldercare providers to access services both inside and outside of traditional working hours.

2. Although few people experience aging in the same way, and therefore eldercare can sometimes be more episodic and crisis driven than childcare, employees who must provide eldercare at a distance have unique needs that could sometimes be anticipated in advance. Options for time banking, reduced workloads and
flexibility will be important for supporting their productivity and continued engagement as valuable workers.

3. Declining social services in rural areas and changing family demographics put a heavier burden on employees who provide informal care to seniors in rural areas or who must take responsibility for caregiving alone. Workplace support is even more important for these groups.

4. Increased expenses associated with caregiving can add significant stress for employed eldercare providers. Creative initiatives to help reduce costs in the short and longer term should include economic support, pension and benefit protection, and job protection as part of program goals.

3. Employee Assistance Programs (EAPs) and Other Family-Friendly Programs/Policies

A. What Do We Know Already?

1. Flexible work arrangements and eldercare information and referral services are available to only a limited number of employees. Eldercare services are increasing, but are rare as a workplace benefit.

2. EAPs generally aim to assist employees with psychological and social problems.

3. Larger organizations are more likely to have EAP services.

4. Traditional EAP mandates rarely focus on family care and may not be effective in providing information and support for eldercare providers.

Saskatchewan Labour (1998) suggests that a family-friendly workplace is one where employers and employees are able to talk about the needs of elderly parents without it being thought of as inappropriate or unprofessional; where employees feel that they could stay home with a sick parent without having to lie; and where employees feel that they can expect fairness and respect when asking for some flexibility for short-term family emergencies or when dealing with family issues (Saskatchewan Labour, 1998). It is obvious that such attributes would be particularly helpful for employees who are eldercare providers.
Studies of the prevalence and use of family-friendly policies and practices that are offered by Canadian workplaces show that flextime is the alternative work arrangement most often available to employees, with telework, childcare services and (the rarest) eldercare services available to significantly fewer employees (Comfort, Johnson et al., 2003; Ferrer & Gagne, 2006). In general, access to flexible work arrangements and family-friendly practices has been found to depend most on one’s occupation, industry and firm size rather and that there is a mismatch between employees’ needs and what is available to them. In fact, it has also been shown that the use of work-based family-friendly policies is more common among employees who don’t actually need them for family caregiving. For example, Figure 4 shows that when the availability of different family-friendly policies is compared for employees in different age groups, it appears that participation in flextime is most often available to younger employees and childcare services are more likely to be available to aging employee groups (Comfort, Johnson et al., 2003).

According to the CCH firm, although eldercare programs were considered to be on par with both emergency childcare and onsite childcare as effective programs that reduced employee absenteeism rates, when asked if demographic changes in the workforce would affect their offerings of work-life programs, three-in-four companies believed that it would not. Nevertheless, by 2006 the number of employers offering Eldercare Services (largely information and referral through their EAPs) increased to 42 percent, suggesting that eldercare is of increasing concern to U.S. business.
Figure 4: Percentage of Employees Reporting Availability of Family-Friendly Services, by Age and Gender and Age Group

Adapted from Comfort, Johnson & Wallace, 2003
Employee Assistance Programs (EAPs) are frequently viewed as a potentially valuable source of support for employees who are having difficulty meeting the demands of work and eldercare. Traditionally EAP services were designed to assist employees in dealing with psychological and work related problems associated with addiction and substance abuse. Larger organizations tend to have some provision for employee access to this service, but it is less likely that smaller companies subscribe to these services or that self-employed caregivers have access at all (Medjuck, Keefe et al., 1998). Since the mandate of EAPs focuses more directly on individual employees’ issues, and since the counseling services are often limited and short-term, this initiative may not be a reliable support for those who seek assistance for problems related to eldercare over the longer term (Medjuck, Keefe et al., 1998).

B. Emerging Themes on EAPs and Family-Friendly Programs/Policies

1. EAPs are not rated highly by some managers as programs that serve to reduce employee absenteeism.
2. The goals of EAP programs are often focused on improving productivity and reducing absenteeism, rather than on service provision issues.
3. EAP work-life programs are growing faster than traditional EAP programs.
4. Analysis of work-based programs suggests that the needs of employees providing eldercare are often considered to be less important than those who provide care for children.
5. Some companies provide innovative models of programs that show promise.

Employee Assistance Programs (EAPs)

Although it appears that EAPs may be used more by employees than many other work-life benefit programs, some research studies suggest that EAPs are not considered by managers to be as effective in reducing caregiving-related absenteeism as other work-based programs (Commerce Clearing House, 2006). Moreover, research on EAPs found that many EAP services were restricted to problems associated with drug and alcohol problems and few addressed issues associated with eldercare (Medjuck, Keefe et al., 1998). Among those that did address caregiving issues, the emphasis was on improving the productivity of the individual worker and was not concerned with attending to
broader issues and interventions within or outside of the workplace that might be affecting the worker’s well-being (Medjuck, Keefe et al., 1998). In almost all cases, these researchers found that organizational documents often outlined the role of the EAP primarily in terms of helping employees whose job performance had been adversely affected by health problems. Furthermore, they also found that confidentiality was not guaranteed in all EAPs, and often no such assurances were made in documents that outlined the services. Less than one third of the EAP documentation studied by Medjuck, Keefe et al. provided information on assessment and referral. Only 6 of 26 documents specified that the employer would pay for the EAPs, or that the employee would be granted time to participate in the EAP during working hours (Medjuck, Keefe et. al., 1998). Csiernik (2006) also found that there were important weaknesses in the ways that EAPs are delivered and evaluated for their effectiveness within organizations. Supporting what was found by Medjuck, Keefe et al., Csiernik found that nearly one-third of organizations sampled used a hybrid model of EAP delivery that combined the services of at least one external professional counselor with internal volunteers who were not always qualified or trained to provide counseling services. Furthermore, although 144 of 154 organizations responding to the survey allowed family members to use the company program, in most cases part-time employees, workers on probation, seasonal workers, retirees and laid off employees did not have access to EAP support. In addition, of 102 companies that reported on their usage rates, 19 different formulas were used to calculate usage statistics, and some organizations did not assess the program’s ability to assist employees in need at all.

Research shows that a significant number of EAPs were created by a joint labour/management group as opposed to being initiated by management, Human Resources or occupational health units alone. The WarrenShepell Research Group (2004) found that the use of EAP work/life programs was increasing faster than more traditional EAP programs, but there was a still a very low uptake of EAP related eldercare programs. They suggest that improving the availability and quality of work-life programs may provide competitive advantages for organizations that want to attract employees with specific employment skills and talents (WarrenShepell Research Group, 2004). Moreover, they also suggest that the use of such programs will “…result in a higher
quality of life among employees, the effects of which enhance employee and organization performance throughout work-to-life facilitation” (WarrenShepell Research Group, 2004).

According to the WarrenShepell research, of the caregivers that do not have access to an EAP, about two thirds felt that they would use it for eldercare if it were available for this purpose. Nevertheless, care for an elderly family member is seldom included in documents that outline EAP services. WarrenShepell (2004) highlights U.S. research that shows that only 23% of organizations offered support to employees for eldercare issues, usually in the form of resource and referral services through their EAP. However, they also suggest that the demand for work-life programs over traditional EAP-type counseling is growing. For many employed caregivers, effective support for them in their role as caregivers would require a multi-pronged form of support that might include developing options for a reduced work load or more flexibility, information and referral to services and supports for themselves and the individuals they care for, and counseling and advice to support care planning and management and reduce personal stress.

Other Family-Friendly Programs/Policies

Research on other existing family-friendly policies and practices has shown that, in spirit at least, the needs of employees who provide eldercare have been treated as less important than those who provide care for children – leaving caregivers of elderly people to their own resources to find ways to manage and provide for the recipient’s needs. For example, as mentioned earlier, in their analysis of Canadian family leave policies, Medjuck, Keefe et al. (1998) found that there are significant differences in the number of leave options available to care for an ill child versus those available to employees who are caring for an elderly parent. There are also often requirements of co-residency, and policies in general allowed for time off for both the provision (hands-on care) and management (arrangement) of child care – but only the management of eldercare. In an analysis of CARNET Work and Family Survey data, Rosenthal, Martin-Matthews et al. (2007) found that “care management” is a meaningful construct that is separate from that of “direct care”, and that it is important that “care management” not be seen as solely
arranging formal services. They found that employed caregivers who were engaged in both managerial and direct care were engaged in the highest number of hours of providing care, whereas those who provided only managerial care were engaged in the fewest hours. Interestingly, men who provided only managerial care tended to report higher incomes than those who provided direct, or “other” care and more often tended to live significant distances away from the older relative.

Medjuck et al. also illustrate that many workplace eldercare policies can only be accessed at the discretion of supervisors who can turn down requests for benefits if they perceive that the request does not relate directly to the employee’s job. This means that access to alternative work arrangements and additional support is not available to all employees equally, and some, but not all, will need to make significant accommodations and sacrifices to provide care.

When government-sponsored or workplace supports are not accessible for working caregivers to draw upon, they may become ‘conscripted’ into providing eldercare as well as managing it. Particularly for women who are poor and regardless of their culture, there is often little choice but that they will be required to provide care to a parent in need, regardless of the distance, by virtue of their lack of resources to do otherwise. By the same token, without support, some caregivers reach their breaking point and are forced to “choose” to leave their jobs in order to provide care. As Armstrong and Kits suggest: “Caregiving can be voluntary only if there is access to alternatives and if there are the kinds of supports available that allow choices to be made” (2001, p. 37)

At the CFWW academic roundtable on Balancing Work and Eldercare, Keefe suggested that we must continue to highlight not only the gaps in government caregiving policy, but also successful workplace models that assist caregivers to meet the demands of work and family, and the opportunities where organizations can do more. The literature does highlight some program models that show promise in meeting the needs of employed caregivers and the organizations that they work for. HR Focus (2000) suggests that paid time off (PTO) banks are continuing to gain ground. These programs allow employees a bank of hours to be used at their discretion for all time off (illness, vacation and personal days). In buy-back programs, employees who do not use their entire
allotment can be compensated. In addition, some organizations allow employees to donate unused days off to a company bank for other employees to use if needed (HR Focus, 2000). In Canada, several organizations have been awarded praise for their initiatives. The University of Toronto has a life advisor who provides information to employees on family topics including eldercare. Shell Canada also makes eldercare information available to its employees and provides assistance in finding eldercare services. Ernst and Young have a backup caregiving program that provides emergency care to children, spouses or other relatives. Pfizer provides a top up salary up to 100% for those on compassionate leave for a period of 8 weeks (Vermond, 2005). These examples suggest that organizations have best practice benchmarks available to assist them in developing and testing what may be effective supports for their employees who provide eldercare.

C. Relating EAP and Family-Friendly Policies to Practice

Money spent on EAPs is wasted if programs do not address the needs of employees effectively.

1. Research suggests that organizations should review the goals and resources of EAPs with respect to promoting work-family balance and make stronger links between EAPs and administrators to identify unmet needs, including support for employed eldercare providers to help address them.

2. Governments and organizations need to scrutinize labour policies to ensure that those who provide eldercare do not face barriers to accessing workplace or government benefits and supports. Policies and initiatives must reflect the same respect for the needs of seniors and their caregivers as there is for caregivers of other family members.

4. After Eldercare – Work and Bereavement

A. What Do We Know Already?

1. Little research is available on this topic.

2. Current provincial labour codes are not adequate.
3. Few organizational policies that address bereavement consider the impact of death on colleagues or friends.

There are not many Canadian research studies that explore the issue of bereavement in the workplace; yet the loss of a parent or close friend can have a significant impact on the caregiver, and this grief can spill into the realm of the workplace. McCracken (2005) notes that sometimes as the health of the care recipient declines, the caregiver may experience what is called “anticipatory grief” before her/his loved one has even died. Zarit (2004) found that at the end-of-life stage, caregivers were more likely than non-caregivers to be depressed (Zarit, 2004). In fact, U.S. research shows that between 40% and 70% of primary caregivers have clinically significant levels of depression, and an elevated risk of death themselves compared to those not providing care (Zarit, 2004).

The Canadian Labour Code provides only 3 days of bereavement leave, and many have noted that this is not nearly adequate (Canadian Television Network, 1999). In 2006, the Government of Manitoba changed its Employment Standards Code to include 3 new unpaid family responsibility/sick days and 3 new unpaid bereavement days for death in an employee’s family. Few organizations have bereavement leave policies, and Rinaldo (Canadian Television Network, 1999) points out that co-workers, who are in many cases extended family by virtue of their friendship with their colleague, are often overlooked in bereavement policies as well.

B. Emerging Themes on Work and Bereavement

1. Co-workers may also be grieving, even as they are asked to assume work of the bereaved caregiver is an issue.
2. Reactions to grief can be manifested long after the death of the recipient.
3. Eldercare providers who work in the helping professions may be at greater risk.

Employers should be aware of the additional strain that grief can cause co-workers if they must assume extra work responsibilities while their grieving co-worker is accommodated (Centre for Suicide Prevention, 2001). Responses to grief vary, but may
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include mental lapses, decreased energy, difficulty in making decisions, anxiety, helplessness, and inability to concentrate (Eyetsemitan 1998). In extreme cases, individuals may experience “complicated grief”, whereby there is a sense of disbelief, anger and bitterness, and recurrent pangs of painful emotions and preoccupations with thoughts of the loved one. Research suggests that complicated grief can affect 10-20% of bereaved persons (Canadian Mental Health Association, 2005; Schulz, Boerner, Shear, Zhang & Gitlin, 2006). Furthermore, reactions to the death of a loved one can first manifest themselves even months after the death has occurred – a point that may not be appreciated by managers and co-workers (Centre for Suicide Prevention, 2001).

Often the newly bereaved are overwhelmed and need assistance with finding information about leave, benefit entitlements and in filling out paperwork associated with their pay cheques, medical claims or life insurance benefits, at the same time that they must make funeral and/or travel arrangements. Eliminating the pressure to perform is one way an employer can offer support (Centre for Suicide Prevention, 2001). In addition, recognizing that some employees return to work too quickly is important, as in the long-term this can cause symptoms of grief to escalate (Centre for Suicide Prevention, 2001).

Rowling (1995 in Centre for Suicide Prevention, 2001) found that workers, particularly those in teaching and the helping professions, felt that they were expected to continue to act in a professionally appropriate manner, despite the fact that this counteracted their personal responses to grief. Suppression can have adverse effects on employees who are experiencing complicated grief, as well as for the workplace, if stifled grief interferes with the ability to work.

C. Relating Caregiver Bereavement to Practice

It is important to recognize grief and to understand that it may happen a significant time after the death of a loved one.

1. Depression is a common symptom associated with grief that can change workplace behaviour. It can manifest itself immediately or a long time after the death of a loved one occurs.

2. Although the Canada Labour Code suggests 3 days for bereavement leave, it is important to ensure that employees do not return to full-time work before they are ready.
3. The newly bereaved may need assistance with paperwork and benefits as well as time to attend to settling estates.

4. It may be helpful to support employees by helping them to understand that grief is a process that takes time. Managers should refer employees to EAP counselors or others if they feel that an employee’s grief is affecting her/his health or the well-being of others.

5. Conclusions, Gaps and Next Steps

This systematic review provides a valuable tool for better understanding the circumstances surrounding the issues of combining work and eldercare in Canada. It has highlighted the needs of employees who are also eldercare providers and, to a lesser extent, the recipients who depend upon them. It has validated the issues that are of concern to caregivers and recognized the challenges that organizations face in supporting caregivers. It has identified some best practices for building organizational and community capacity to better meet the needs of employed eldercare providers.

The themes of gender, work and eldercare; the needs of caregivers, recipients and organizations; work-based EAPs and family-friendly programs and services; and bereavement form a solid framework for understanding some of the issues associated with combining employment with eldercare. While some of the issues of the past continue to evolve, new issues emerge to challenge our perspectives and to pose new questions. It is increasingly important that employers, governments and employees work together to strengthen policies that are effective and to re-construct or abandon policies and practices that create barriers for those in need who can not access them. Successful workplace environments are not born, but evolve through creativity and insight. As the population continues to age and workplaces adjust to a shrinking labour force with dependent care responsibilities, the policy, practice and service issues related to balancing employment and eldercare will continue to be a concern.

In its survey of Canadians who provide eldercare, Statistics Canada was able to draw out a “caregiver wish list” of what supports would assist employees in helping others. Occasional relief/respite was the most frequently mentioned support for all levels of caregiving, but for those who provided high-intensity caregiving it was mentioned by 8
in 10 respondents (Pyper, 2006). Flexible work arrangements was identified as a critically important way to ease the pressure of caregiving, particularly for caregivers who work long hours. Financial compensation was mentioned by more than half of high-intensity caregivers.

There is a considerable volume of research on the incidence of caregiving, the types and amounts of care provided, and the consequences of caregiving for family members and friends. Synthesizing the literature across these many categories and circumstances of caregiving is challenging, because the nature of care can be quite different in different circumstances, and particularly because since care demands and experiences often change over time. As is common in any area, widely different samples, measures and methodologies are used in research, which can impede the development of a consistent picture and clear recommendations. We also know much less about some of the consequences of caring than others. For policy decision-making purposes it would be especially useful to know more about what is needed to address the economic consequences experienced by caregivers of elderly people (Lero, Keating, et al., 2007)

We also know little about the dynamics of caregiving over time—how care needs change over the life course or over the course of a disability/illness, how caregivers’ capacity to care changes over a caring career, or about the long term consequences of either a single caregiving episode, or a career of caring. Surprisingly little research has taken a systems perspective which would explore the differences among caregivers and care networks that reflect different cultural backgrounds, lifestyles and values, urban-rural location, differential access to services, or caregivers’ economic resources or employment circumstances. Almost none of the existing research takes account of more than a very few of these characteristics simultaneously.

While research on cultural diversity among eldercare providers is becoming more common, it is still rather scarce, especially within the Canadian context. It also tends to be rather fragmented by ethnic origin, with some cultural groups more extensively studied than others. Caregiving at a distance continues to remain a relatively unexplored area but one that increasingly employees and employers are likely to face.
As Wilkins and Beaudet (2000) concluded, “the informal network operates in concert with the formal delivery system” (p. 49). In fact, it seems that mitigating some of the hardships of care by bringing in formal care services can actually extend the capacity of the family/friend care network, enabling them to continue caring longer and maintaining the capacity to combine employment and care. Family/friend and formal care providers may have conflicting practices and agendas however. Governments and institutions may be more focused on cost savings, while family/friend carers are likely focused on the care recipient’s needs. Policy and practice rhetoric extols the virtues of partnerships among care receivers, caregivers and service providers, but questions arise as to what optimal partnerships look like and how to achieve those, especially in light of the complexity and diversity of care relationships.

Policy makers and practitioners often speak about and behave as if large and strong networks of supporters and carers surround those in need. While our knowledge about eldercare networks is growing, it is still rather limited. In a policy context questions remain as to whether policies affect the size, composition or organization of care networks, and whether they strengthen or weaken the capacity of employed caregivers, or of the care networks.

It is generally believed that we care for family members and friends in need willingly and voluntarily, out of a sense of obligation or reciprocity, or simply because we care about them. Yet caregiving can be voluntary only if real alternatives are available that allow choices to be made. In light of evidence about variability in access to services across geographic regions, cultural groups, family forms and structures, and in light of recent policy reform that has resulted in reduced availability of formal support and care services, questions arise as to whether caregiving and care receiving are voluntary, and whether the ways in which care is currently organized are themselves constructed by policy makers in ways that reflect little consideration about health promotion and long-term consequences for employed caregivers. Making an effort to learn about and understand the context of the employed caregiver is thus of fundamental importance for organizations and policy makers.
Demographic trends including population aging, an older workforce, and labour shortages also suggest that the experience of combining employment and caregiving will become more common. It is therefore important to consider policy options and workplace practices that can provide flexibility and appropriate assistance to employees with significant caregiving responsibilities in order to support both the quality of care provided and employees’ productivity and continuing attachment to the labour force. There have been important international comparisons of public policy and workplace supports for working parents, but limited work on public policy and workplace supports for the broader range of family caregivers such as those providing eldercare. There is obviously much more to learn.

The American Business Collaboration for Quality Dependent Care (ABC) (2007) is a groundbreaking alliance of leading U.S. companies that have partnered to ensure that their employees have access to quality dependent care programs and services to help them manage their work and personal responsibilities. This initiative is a good model of organizational and community capacity that can be used to examine and build on to develop innovative ways to address issues related to combining work and eldercare in the Canadian context. Currently ABC is made up of companies that include Deloitte & Touche, Exxon Mobil Corporation, IBM Corporation, Johnson & Johnson, and Texas Instruments. The basic principle of the partnership is the belief that companies accomplish more when working together rather than alone. Focusing on addressing dependent care issues to enhance the work/life balance for employees, companies associated with ABC see significant impacts on their bottom lines and have observed measurable results that are linked to their actions (American Business Collaboration for Quality Dependent Care (ABC), 2007).

At the more local level, valuable opportunities can be seen in developing and delivering information sessions that are useful for caregivers through public workshops, seminars and other learning platforms. Interactive fora where researchers, caregivers and service providers can exchange knowledge with each other helps to build upon foundations that are already beginning to form. Finally, workplace and community partnerships that explore cost effective ways to meet the needs of employees who are
trying to achieve better work-family balance, or that seek out consistent and productive ways to measure the success of existing initiatives will be very helpful.

The Centre for Families, Work and Well-Being at the University of Guelph and Homewood Health are well suited to partner with governments, businesses and community health and social service agencies to develop innovative models and resources for employers and for communities interested in the range of important issues related to combining work and eldercare. It is also important to extend the research in this area and to find ways to mobilize knowledge so it can be used effectively in workplaces and to inform public policy. We look forward to the opportunity to work together towards those ends.
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