Responsibilities for Care throughout the Life Span:

A Brief Look at the Family and Long-Term Care Laws of Sweden, Canada and the U.S. with a particular focus on the Ageing

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Abstract

The provision of long-term care is affected by familial support because to a large extent care is still considered a familial task in most countries – one that is mainly performed by women. As an increasing proportion of women are entering the labour market, and the ratio between those in need of care and those who are potentially able to provide it is changing, now is an interesting time to consider legal frameworks for care and the delineation of responsibility between the state, family and individual.

This paper presents some of the family and long-term care laws in view of the responsibilities for caregiving across the life course with a particular focus on the ageing. The paper independently discusses the laws of Sweden, Canada (with a focus on Ontario), and in parts that of the U.S. (with a focus on Maryland), and then the paper draws comparisons and highlights the values and ideology that inform them.

Although all three selected nations share the similarities of being democratic, developed nations with strong social and economic institutions, their legislative approach has not been uniform. Rather the legislation reflects the political and social values of each jurisdiction. In Sweden, consistent with a social welfare ideology, the state chooses to place the balance of responsibility onto itself with strong support mechanisms offered to the family and individual. By contrast, Canada (Ontario) and to a larger extent the U.S. (Maryland) focuses more on individual oriented solutions where the state plays a smaller role.
Introduction

“Long-term care” usually includes health, social, housing, transportation and support services for people with physical, mental or cognitive limitations who wish to live as independently as possible. The provision of long-term care is affected by familial support because in most countries care is still considered a familial task – one that is mainly performed by women. As an increasing number of women are entering the labour market and the ratio between those in need of care and those who are potentially able to provide care is changing, it is timely to examine legal frameworks for care and the division of responsibilities between the state, family and individual.

This paper describes family and long-term care laws with a particular focus on the ageing. Three jurisdictions are considered: Sweden, Canada (with a focus on the province of Ontario), and the U.S. (with a focus on the state of Maryland). These jurisdictions provide a good basis for comparison because they are both similar and different. The jurisdictions are similar in that all three have well-established legal systems and are (or are part of) developed nations and independent democracies with strong social and economic institutions. At the same time the jurisdictions have different legal systems. Canada and the U.S. are common law countries while Sweden is a continental law country. Sweden has strong social institutions and a commitment to state responsibility; the U.S. focuses on private responsibility and the importance of the individual; and Canada falls somewhere in between. Sweden’s population can be characterised as homogeneous while the U.S. and Canada reflect more cultural diversity. In terms of age, Canada and the U.S. are relatively young nations, while Sweden is older.

The choices of Ontario and Maryland as representatives of Canada and the U.S.A. were influenced in part by practical factors such as the accessibility of legislation, and the availability of recent analysis of the legislation and systems. Ontario and Maryland were also logical choices. Ontario contributes about 41% of Canada’s GDP and has 11.7 million

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1 Long-Term Care Laws in Five Developed Countries (WHO, 2000) at 4.
3 One author has suggested that comparisons of long-term care between the U.S. and Canada may be more useful than between the U.S. and any other nation because of the shared cultural heritage, common contemporary influences, shared media, age distributions, etc. See R.A. Kane and R.L. Kane “Long –Term Care for the Elderly in Canada” in T.A. Schwab ed., Caring for an Aging World (New York: McGraw-Hill, 1989) at 193. [hereafter Aging World]
4 While this characterisation is something of a generalisation, it is fair to say that the content and historical development of Swedish law in general are far closer to continental law than to common law. “Introduction” in S. Strömholm ed., An Introduction to Swedish Law (2ed) (Stockholm: Norstedts, 1988) at 33. [hereafter Introduction to Swedish Law] For further discussion of Swedish law, see the section entitled “Swedish Law in an International and Scandinavian Perspective” in Introduction to Swedish Law commencing at 32.
5 A thesis for the degree of Doctorate of Jurisprudence by Israel Doron, From Guardianship to Long-Term Legal Care: Law and Caring for the Elderly (Graduate Program in Law, Osgoode Hall Law School, York University, Toronto, 2000) was especially helpful, and some sections of this paper rely heavily upon that work.
residents, making it the province with the largest population, and home to more than one third of Canadians. Also, the age distribution of Ontario’s population is very similar to that of the nation as a whole and thus it is representative of the population’s needs. Maryland’s population is also similar to that of its nation. In addition, Maryland has recently reformed some of its relevant laws, including those on adult guardianship, and this reform took into account the experience of both Maryland and other states.

The systems of Sweden, Canada, and the U.S. (in part) are examined in terms of: the country’s legal system, demographics, the ideology informing health care and the division of responsibilities within government; responsibilities for care between parents and children, between spouses, and between other relatives; responsibility to provide care to the elderly including to adult parents; and finally guardianship.

The analyses were derived from actual legislation, scholarly writings and other publications. An in-depth analysis of actual practices is beyond the scope of the paper though clearly, legal culture, norms and customs affect the implementation and impact of laws. With respect to Sweden, it should be noted that the legislation provides a framework for local authorities, but there is considerable room for adjustment in application and supervision. In most cases some kind of interpretation is necessary to clarify the law, and preparatory materials are very useful in this regard. Detailed consideration of these materials and of judicial decisions is beyond the scope of the paper. However, publications by the Swedish government and public agencies are used to put the legislation in context. In Canada and the U.S., common law is often critical to the interpretation of legislation. However, common law is not considered at great length here, as it was unavailable. Where possible, legislation is put in context using scholarly articles and annotated codes. Finally, it should be noted that this paper is intended to provide a broad comparative overview, not a detailed analysis of legal frameworks for long-term care. The paper offers a general description of the legislative systems of the three countries and provides a foundation for more specific analysis.

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8 Population broken out by percentages in age groups 0-14 15-65 65+

<table>
<thead>
<tr>
<th></th>
<th>Canada</th>
<th>Ontario</th>
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<tbody>
<tr>
<td>0-14</td>
<td>19.1%</td>
<td>19.5%</td>
</tr>
<tr>
<td>15-65</td>
<td>68.4%</td>
<td>68.0%</td>
</tr>
<tr>
<td>65+</td>
<td>12.5%</td>
<td>12.6%</td>
</tr>
</tbody>
</table>


9 Doron, supra note 5 at 304.

10 Guardianship is a legal relationship. Once a legal authority (such as a court) determines that a person is incapable of handling his or her own affairs, then the legal rights, possessions and decision-making powers of the person are transferred to the guardian. This definition is based on *Abuses in Guardianship of the Elderly and Infirm: A National Disgrace* (Washington D.C.: Subcommittee on Health and Long Term Care, One Hundredth Congress, 1987) as cited in Doron, supra note 5 at 13.


12 Ibid, at Sweden-16.

13 The lawmaking process in Sweden generates volumes of printed matter, such as proposals referred to the Council on Legislation, the Council’s opinion and government opinions. Courts, authorities and lawyers rely on these materials as an important source of interpretation. *Law and Justice in Sweden* (Swedish Institute), online: [http://www.si.se/infoSweden/328.cs](http://www.si.se/infoSweden/328.cs) (Accessed 2001-07-24).

14 Judicial decisions are also an important source of law, but not to the same extent as in common law countries.

15 Part of the *Criminal Code of Canada* and the *Family Law Act* of Ontario was available with annotations.
SWEDEN

Background

a) Legal System

Statutory law in Sweden generally prevails. However, there is no codification of Swedish law like the German Civil Code (Bürgerliches Gesetzbuch, BGB) or the French Code Civil. The Swedish code of 1734 is divided into “books,” but these “books” are not so much a reflection of a scientific system as an effort to put together statutes dealing with various aspects of life. The books of the present Swedish Code include the Code on Marriage (MC) and the Code on Parents and Children (CPC), both of which are useful for understanding responsibilities for care. New statutes in such areas as intellectual property, administrative law and social legislation are arranged chronologically and published annually Sveriges Rikes Lag, (“Code of Laws of the Realm of Sweden”).

Swedish family law has undergone major changes in recent years. For example, a new MC came into force in 1988, and in 1998 new rules were set out under the CPC. A new Social Services Act (SSA) was introduced in 1982, revised in 1998 and 1999 and again in 2001. The latest SSA entered into force on January 1, 2002.

b) Demographics

Sweden has 8.8 million people with 19% under the age of 15, and 22% aged 60 or older. Consequently, the percentage of the total population that is elderly is amongst the highest in the world.

c) Ideology Informing Health Care

Sweden is a welfare state with a commitment to publicly funding and delivering health and social services to all citizens. With some qualifications, the Swedish welfare system is characterised by universalism. That is, Sweden does not focus on certain hard-pressed groups; social rights and financial security are guaranteed to all citizens without application procedures or means testing.

16 Introduction to Swedish Law, supra note 4 at 34.
17 Note that the term “book” is used interchangeably with the term “code”.
18 There are also books on successions, real property, building, commerce, crimes (The Penal Code), judicial procedures (civil and criminal) and enforcement. Introduction to Swedish Law, supra note 4 at 34.
19 Ibid, at 35.
20 Family Law (Stockholm: Ministry of Justice, 2000) at 7. A copy can be obtained by fax: +46 8 20 27 34.
23 To put this into perspective, in 1998, 10% of the total world population was aged 60 or older. The corresponding figure for Europe was 20%. Ibid.
24 Social Insurance in Sweden (Swedish Institute), online: http://www.si.se/docs/infosweden/engelska/fs5z.pdf [hereafter Social Insurance]
The *Health and Medical Services Act* (HMSA) provides the basic terms and conditions for the delivery of health care and establishes who is entitled to receive health care.\(^{25}\)

**Goal of health and medical services**

§2 Health and medical services\(^{26}\) are aimed at assuring the entire population of good health\(^{27}\) and care on equal terms.

Care shall be provided with respect for the equal dignity of all human beings and for the dignity of the individual. Priority for health and medical care shall be given to the person whose need of care is greatest.

According to the preparatory work of the HMSA, care on equal terms means that regardless of location, everyone can use the health care system when needed and under the same conditions: receiving care is not dependent upon age, gender, ability to take initiative, education, financial means, nationality or cultural differences.\(^{28}\) Further, the preparatory work suggests that society should take care of its especially vulnerable groups such as the elderly and handicapped.\(^{29}\)

The SSA assigns “last resort” responsibilities for social welfare to municipalities, which are to promote economic and social security, equality of living conditions and active participation in the life of the community.\(^{30}\) The SSA requires that local authorities help individuals to live independently and to maintain contact with others by providing assistance in the home, transportation and other services needed.\(^{31}\)

d) Division of Responsibilities

The national government introduces legislation that sets out the framework and objectives\(^{32}\) and exercises control with the help of national agencies.\(^{33}\) However, services are not uniformly and equally distributed throughout the country; actual provision varies

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\(^{25}\) Westerhäll, supra note 11 at Sweden-23.

\(^{26}\) The term “health and medical services” is defined in HSMA, §1 as measures for medical prevention, investigation and treatment of disease and injury, and also includes ambulance services and care of deceased people. (Special provisions apply concerning dental care.) One author has indicated that this section covers both patient care carried out by the local government and health care provided by others such as employers, schools, and private providers. Westerhäll, supra note 11 at Sweden-49.

\(^{27}\) The definition of ‘health’ is not self-evident. The preparatory work of the HMSA states that good health is one of the indicators of the conditions and qualities under which people live. *Prop.* 1981/82:97, p. 113 cited in Westerhäll, supra note 11 at Sweden-50. Further, it is pointed out that meaningful free time, absence of stress in the workplace and overall physical and psychological well-being ought to receive greater attention than they normally do. Westerhäll, supra note 11 at Sweden-50.

\(^{28}\) It is important to note, however, that this is the overall objective, and it is not necessarily met in every individual case. Westerhäll, supra note 11 at Sweden-50.

\(^{29}\) Ibid. For further discussion of the purpose and principles behind §2, see Westerhäll, supra note 11 at Sweden-50 to Sweden-53.


\(^{31}\) Ibid.

\(^{32}\) The national government is also responsible for formulating policy targets, developing action plans, distributing funds and evaluating national efforts to promote public health.

\(^{33}\) For example, there are the National Board of Health and Welfare, the National Institute of Public Health and the Swedish Institute for Infectious Disease and Control.
According to international standards, the county councils (which cover a number of municipalities), as well as the municipalities in Sweden have a high degree of autonomy. Both have the right of taxation and the freedom to finance and shape their operations. Despite a tax levelling system to allow for roughly the same level of services, regional differences are considerable. At the same time, the National Board of Health and Welfare has regional offices responsible for supervising the care provided, but does not have the resources to scrutinise services in detail. The laws are also very general, allowing for a broad range of interpretation and application. For example, it has been said that in terms of governmental responsibility, there is hardly any real national regulation of care of the elderly beyond a vague body of legislation. The delivery systems are further complicated by the separation of health and social welfare services, since different groups of government bodies are involved in implementation.

**Family Law**

a) Obligations of Spouses

A general provision of the MC establishes that spouses are to be faithful and considerate of one another. Since the abolition of the principle of fault as grounds for divorce, no sanctions are connected with failure to comply with this provision. The section is set out below.

**Part I. Ch1.**

§2 Spouses shall show faithfulness and consideration for one another. They shall jointly take care of their home and children and in consultation promote the best interests of the family.

Spouses are responsible for their own and their spouse’s maintenance. If a spouse cannot maintain his / herself, the other is responsible for meeting the spouse’s personal needs according to ability. Money or other support provided to this end becomes the property of the recipient spouse. The relevant provision of the MC is set out below.

**Part III Ch.6 Support**

§1 Spouses shall, each according to their ability, contribute to the support needed to meet their joint and personal needs...

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34 A. Zappolo & G. Sundström, supra note 30 at 22.
35 *Policy for the Elderly* (Ministry of Health and Social Affairs, 2001). A copy of this document can be obtained by calling the Ministry at +46 8 405 10 00. [hereafter Policy for the Elderly]
36 *The Care of the Elderly in Sweden* (Swedish Institute, 1999), online: http://www.si.se/docs/infosweden/engelska/fs8.pdf [hereafter Care of the Elderly].
37 Ibid.
38 Ibid.
39 Zappolo and G. Sundström, supra note 30 at 30.
40 L. Tottie, “Family Law,” in *Introduction to Swedish Law* supra note 4 at 205. Swedish marriage law no longer deals with ethical or personal questions at all.
42 Ibid, at 11. In reality, most Swedish families with children have two incomes. *Swedish Family Policy* (Stockholm: Ministry of Health and Social Affairs, 2001). A copy of this document can be obtained by calling the Ministry at +46 8 405 32 99.
§2 If the contribution which one spouse is to make is not sufficient for that spouse’s personal needs or for the payments which that spouse otherwise attends to for the support of the family, the other spouse shall contribute the money that is needed.

b) Parents and Children

The CPC establishes a child’s general right to care. A corresponding obligation to meet the child’s right is imposed on the custodian. A child is under custody until the age of 18, or until married if the child marries before the age of 18. If a child is engaged in full-time study beyond the age of 18, the custodian’s responsibility continues until the child is 21, but not beyond 21.

Custody belongs to one or two adult persons. Married parents have joint legal custody and this status automatically continues upon divorce. The primary consideration with regard to custody is the best interests of the child. As the child grows older and more mature, the custodian is under a legal duty to increasingly consider the views / wishes of the child. Some of the relevant sections of the CPC are reproduced below.

Chapter 6. Custody and contact
Introductory Provisions
§1 Children are entitled to care, security and a good upbringing. They shall be treated with respect for their person and their distinctive character and may not be subjected to corporal punishment or any other humiliating treatment.

§2 Both or one of the parents of a child shall have custody of that child, unless a court has entrusted custody to one or two specially appointed custodians. Custody of a child shall continue until he or she attains the age of eighteen years or enters into marriage before that age.

A person who has custody of a child is responsible for the child’s personal affairs and shall ensure that the needs of the child referred to in Section 1 are met. The person with custody of the child is also responsible for ensuring that the child receives the necessary supervision, having regard to his or her age, development and other circumstances, and shall see to it that the child is satisfactorily maintained and educated. In order to prevent the child causing damage to the detriment of any other person, the person with custody shall, furthermore, ensure that the child is kept under supervision or that other appropriate steps are taken. …

43 Family law only deals with legal custody. The legal custodian(s) determines the daily care of the child. The person(s) with legal custody is usually the person(s) with physical custody. Consequently, the legal custodian(s) usually takes care of the child, but sometimes, as in the case of foster parents, physical custody is given to a third party. In such a case, the custodian may take the child back again. See Tottie, supra note 40 at 216.

44 Family Law, supra note 20 at 32. Minors cannot be appointed custodians CPC, ch. 6 §10a.

45 See CPC, Ch. 6 §3. Joint custody continues upon divorce provided that neither parent has requested that joint custody be dissolved, and if joint custody is not incompatible with the best interest of the child. Family Law, supra note 20 at 33. If parents marry after a child is born, they obtain automatic joint custody by virtue of the marriage. If a child’s parents are unmarried when the child is born, the mother has custody. If parents agree to alter custody, they can apply to the court for joint or sole custody, or resolve the custody issue themselves by agreement. If only one parent wants to alter custody, that parent may commence court proceedings. For more details see Family Law, supra note 20 at 33 and CPC, Ch 6., which deals with custody and contact.

46 CPC, Ch. 6 §2a.

47 CPC, Ch.6 §11. Also see Tottie, supra note 40 at 215-16.
c) Other Filial Obligations
There is no imposition of care duties upon siblings or extended family.

d) Intervention
Social service interventions for children and young people are generally provided in a voluntary manner, with the support of the SSA. Care outside the home often occurs with the consent of the parents.\(^4\) When a young person has a need for care or protection, which cannot be provided in a voluntary manner, a second piece of legislation, the Care of Young Persons (Special Provision) Act (CYP), may be applied. Three criteria must be met for this act to apply: 1) a deficiency must exist either in the home environment or the young person’s own behaviour, 2) the deficiency must lead to a manifest risk of damage to the young person’s health or development, and 3) necessary care cannot be given by voluntary means.\(^5\) In case of an emergency, the social welfare committee can immediately take a minor into care on a temporary basis while awaiting a final decision on the care issue. It is important to note that the aim of both the SSA and the CYP is to return minors to their own home: care is a temporary measure.\(^6\)

*The Elderly*

a) Filial Responsibility – Adult Children and Parents

In 1956 the *Poor Law* was abolished and replaced by social welfare legislation. Thus there is now no legal obligation for an adult child to support his/her parents. Instead, the SSA emphasises the legal right of the individual to assistance from society.\(^7\)

b) Legislative Framework and Division of Responsibilities

Responsibility for the care of the elderly is split between the different levels of government. The national government realizes policy goals through framework legislation like the HMSA and SSA, and through financial control measures.\(^8\) County councils are responsible for health and medical care. Municipalities have a responsibility to meet the social service and housing needs, and since the 1992 Ädel Reform municipalities also have responsibility for long-term service and care for the elderly.

To reduce government expenditures and provide an alternative to municipal care, provision of elderly care services has been opened to the private sector. Now approximately 10% of elderly services are delivered by private enterprises. Municipal governments, however, are still responsible for overall funding and supervision of elder care, regardless of whether the municipality or private entrepreneurs handle the activities.\(^9\) Other actors like voluntary


\(^{49}\) Ibid, at 32.

\(^{50}\) Ibid.

\(^{51}\) L. Andersson *“Sweden and the Futile Struggle to Avoid Institutions”* in *Working and Caring*, supra note 2 at 101.

\(^{52}\) It may be useful to note that as of 1999, the national policy goals for care of older people include that older people shall: 1) be able to lead an active life, play a role in society and be able to influence their everyday life; 2) be able to grow old in security and retain their independence; 3) be treated with respect; and 4) have access to good healthcare and social services. *Policy for the Elderly*, supra note 35.

\(^{53}\) Ibid. Funding is based on public purchasing involving commercial tenders.
organisations and employers are not expected to be involved in social or health care services when continuity and professional work are necessary.\textsuperscript{54}

c) Benefits

Care for most elderly begins when they begin to make use of home-based services,\textsuperscript{55} and home care is the most commonly used service for the aged in Sweden.\textsuperscript{56} The emphasis on home care is based on two assumptions: individuals are happier and better served when living in the community, and this is also more economical.\textsuperscript{57} Home care services include:

- Home help (assistance with dressing and personal care, shopping, cooking, going to the bank)
- Home health (medical treatment, medications)
- Cleaning and home maintenance (garbage removal, cleaning windows, etc.))\textsuperscript{58}

In order to qualify for special housing accommodations, such as old people’s homes, nursing homes or sheltered housing, the elderly person must need very extensive care and attention.\textsuperscript{59} In fact, 92\% of Swedes live in ordinary homes,\textsuperscript{60} which is in line with community goals to keep people at home as long as possible.\textsuperscript{61} This high figure may in part reflect the fact that grants for housing adaptation make it possible for those with functional impairments to remain in their own homes.\textsuperscript{62} Elder care is heavily subsidized so that recipients pay only a small percentage of actual costs, in the form of co-payments. In the majority of municipalities, charges are based on income and scope of intervention for recipients in ordinary accommodations, and are based on income, irrespective of care needs, for recipients in special accommodations.\textsuperscript{63}

d) Support Provided to Caregivers

While Sweden’s policy is that family contributions to the care of the elderly should be voluntary and serve as an adjunct to public initiatives, families, relatives, friends and neighbours provide a considerable proportion of help and support for elders who have difficulty managing on their own.\textsuperscript{64} Many elderly people have an intact family so that they are

\begin{thebibliography}{99}
\item Andersson, supra note 51 at 101.
\item Few move into institutions without previously having help at home. Care of the Elderly, supra note 36. The number of recipients of home help services decreased throughout the 90’s and interventions now focus on the oldest and those in most need of help. Due to financial constraints, municipalities are considering making needs testing more stringent. Social Services, supra note 48 at 82-3.
\item Zappolo and G. Sundström, supra note 30 at 30.
\item Doron, supra note 5 at 343 in part citing Monk and Cox, supra note 56.
\item In 1999, 8\% of those 65+ were living permanently in special types of housing accommodation. The corresponding figure for those 80+ was 20\%. Policy for the Elderly, supra note 35.
\item Ibid.
\item R.L. Peck., “Does Europe have the answers?: Part 1 In quest of the perfect long-term care” (1999) 48 Nursing Homes: Long Term Care Management 52.
\item Policy for the Elderly, supra note 35. The Housing Act authorises loans and subsidies for impaired elderly, assists in providing both physical and financial access to adequate housing, and provides funds for adaptations and special furniture free of charge to those who need assistance because of impaired mobility.
\item Social Services, supra note 48 at 88. The variation in cost structure by municipality is evidenced by the fact that ten municipalities’ fee structure for ordinary accommodation is based only on intervention.
\item Policy for the Elderly, supra note 35.
\end{thebibliography}
still married at an advanced age, and they have children and other relatives living in fairly close proximity.\textsuperscript{65} For perspective, more than 50% of elderly people live with their spouses, 3-4% live with their children, siblings or other close family members, approximately 40% live alone and only 8% live in accommodations legally defined as institutional.\textsuperscript{66} One study indicated that 8 out of 10 elderly have someone to help them, usually a spouse, but also children and other relatives.\textsuperscript{67} As a result, the role of the family in providing care has changed less than might be expected.\textsuperscript{68}

The government provides direct financial support to families. Since the 1960’s municipalities have been entitled to employ a family member of an elder in need of care due to chronic illness or disease.\textsuperscript{69} The salary of paid caregivers is determined by elder care needs and based on the number of hours required to perform necessary care. The salary is equal to that of a typical home-helper employed by the municipality and is viewed as compensation for lost regular work income.\textsuperscript{70} Since the payment is considered income, it is taxed and earns the benefits of social insurance and pension credits. It is interesting to note that the number of paid caregivers has decreased over the years-- from 18, 500 in 1970; to 10, 600 in 1980; to 6, 000 in 1990; to 4,000 in 1995. On explanation for the decline is that this program occupies a marginal position compared to other public care provided in Sweden.\textsuperscript{71} No law covers a leave of absence from employment for employed caregivers; individuals have to negotiate with their employers.\textsuperscript{72}

Another form of assistance is a paid leave of absence program introduced by the government in 1989. Under this program, employees can take a leave to care for acute or terminally ill family members without significant economic consequences since they receive 75% of their salary. The allowance is taxable. The form of the leave is flexible: it can be taken as full days, half days or hours per day. The elderly recipient of care must give consent, and the doctor must include a statement of the need for care along with the written application. The number of people taking the paid leave has increased, possibly due to increased support for the program. Originally the number of days was limited to 30 in the lifetime of the recipient, but this has been increased to 60. Also, previously, leave could only be taken when the recipient was at home, but now it can be taken when the recipient is in a hospital or nursing home.\textsuperscript{73}

One difference between the paid caregiver program and the paid leave program is that the latter is based on actual income, making it an incentive to all societal segments. The paid caregiver program is more attractive to working class women since those in higher income brackets lose economically by leaving their jobs for a lower salary.\textsuperscript{74}

The government has also made special project funds available to the National Board of Health and Welfare (NBHW) to update and expand support programs for informal caregivers.

\textsuperscript{65} Care of the Elderly, supra note 36.
\textsuperscript{66} Ibid.
\textsuperscript{67} Zappolo and G. Sundström, supra note 30 at 41.
\textsuperscript{68} Care of the Elderly, supra note 36.
\textsuperscript{69} To put this into perspective, of those older and functionally disabled who on Dec. 31/97 had been granted social home help services and/or were receiving home nursing, 2% received help from friends/relatives employed by the municipality as care assistants or the equivalent. Social Services, supra note 48 at 86.
\textsuperscript{70} Home-helper incomes are on the lower rungs of the income ladder. Ibid, at 103-04.
\textsuperscript{71} For further discussion of the decline of informal care giving, see Ibid, at 104.
\textsuperscript{72} Andersson, supra note 51 at 106.
\textsuperscript{73} Ibid, at 105.
\textsuperscript{74} Ibid.
Municipalities and voluntary organisations design local projects and apply for this funding. For example, in one municipality, the caregiver and recipient can stay in a respite centre for 2-3 weeks for a low daily cost. This way the caregiver receives relief, as well as an opportunity to break the isolation often associated with informal caregiving.\

**Guardianship**

In 1988 as part of a major reform of the laws, Sweden abolished the practice of declaring a person legally incompetent and replaced it with two forms of assistance to incapable people: the appointment of a special representative (god man) and the appointment of an administrator or trustee (forvaltarskap). The appointment of a special representative does not lead to loss of legal capacity, and such an appointment is considered preferable to the appointment of an administrator. A special representative can give aid and support and has the power to act on behalf of the principal, but his/her authority does not exclude that of the principal. The appointment of an administrator is a last resort and leads to loss of legal capacity in specific areas. This appointment requires the consent of the person unless the person’s condition makes it impossible for the court to hear his/her opinion. Due process protection measures include the requirement that during any administrative proceeding the person must be heard in person, and statements must be obtained from the spouse and chief guardian.

The court may make an appointment if a person needs help in protecting his/her rights or managing property due to illness, or is in declining health or mentally disabled. However, there are no laws or legal rules specifically about proxy decision making in regard to health care. Families are not deemed automatic substitute decision-makers, and it is unclear whether a special representative or administrator can make health care decisions.

**CANADA**

**Background**

a) Legal System

Canada is governed by the common law system except in the province of Quebec, where the civil law system is in effect. Under the common law system, the court looks to previous case law, whose authority varies with the level of the court delivering the judgement, factual similarities and cogency of reasoning. The doctrine *stare decisis* binds judges to previous applicable cases.

b) Demographics

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75 Ibid.
76 This section relies on Doron, supra note 5 at 340-41 unless otherwise indicated.
77 Tottie, supra note 40 at 220.
78 Some have noted that legal traditions are growing more similar where precedents are being tacitly recognised in civil jurisdictions and the amount of legislation in common law jurisdictions is increasing. See K.R. Redden, ed., *Modern Legal Systems Cyclopedian* (vol. 1 revised, North America) (Buffalo: William S. Hein & Co., 1988) at 1.20.16 for further discussion. [hereafter Cyclopedian].
Canada has a population of 30.3 million people; 79 17% of the population are aged 60 or older and 19% are under the age of 15. 80 Three-generation families living under the same roof represent 6% of all families. 81 In the future, with an increasingly ageing population, this percentage may grow.

c) Ideology Informing Health Care

Canada recognizes the government as the agent responsible for redistribution of wealth and for the welfare of the poor, disabled, elderly and children. 82 The value and principles of the Canada Health Act, 1984 83 (CHA) define the Canadian approach. The CHA statutorily establishes five principles of health care: universality, portability, comprehensiveness, public administration and accessibility. Provinces must meet these conditions to be eligible for federal contributions to provincial health insurance costs.

d) Division of Responsibilities

Historically, health care was not viewed as a matter of national importance in Canada. Rather, health was considered a matter of local or private interest. 84 Consequently, the drafters of the Constitution Act, 1867 did not include health as a specific area of federal or provincial responsibility. 85 However, provinces have used their jurisdiction over hospitals, property and civil rights and matters of local or private nature in the province to establish primary constitutional responsibility for health. As a result, Canadian health care regulation is very decentralised and each province administers public health insurance and maintains its own professional and institutional certification. Nevertheless, the Federal government maintains a considerable degree of control over the shape of the health care system through the CHA and other forms of health spending. 86

Family Law

a) Obligations of Spouses

So long as families reside together and the family is intact, it is likely that needed support will be forthcoming without resort to the law. However, nothing in Ontario’s Family Law Act 87 (FLA) appears to prevent a spouse (or a child) from suing for support while residing

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79 UN Demographic, supra note 21 at 155.
80 World Populations, supra note 22.
81 J.D. Payne, “Family Law in Canada” in M. Baker ed. Canada’s Changing Families: Changes to Public Policy (Vanier Institute of the Family, 1994). To note, this statistic is from the early 1990’s.
83 R.S.C. 1985, c. C-6. [hereafter CHA]
85 Ibid.
86 Ibid, at 117. Since federal payments to the provinces have been declining, there has been consideration about the federal government’s ability to continue enforcing national principles under the CHA. See B. Curtis, “User Fees for the Elderly: Medicare Solution or Dissolution?” (1996) 2 Appeal: Review of Current Law and Law Reform 18 at para 4.
87 R.S.O. 1990, c. F3. [hereafter FLA]
with a person who ought to pay. The obligation to support a spouse and the obligation to support oneself are set out in the FLA, as shown in the passage below.

Obligation of spouses and same-sex partners for support
30. Every spouse and every same-sex partner has an obligation to provide support for himself or herself and for the other spouse or same-sex partner, in accordance with need, to the extent that he or she is capable of doing so.

The test of eligibility for inter-spousal support, then, is based on the need of the dependent and the capability of the other to provide support. Cohabiting partners who meet the statutory definition of “spouse,” and therefore, under an obligation to support each other can form an agreement regarding support obligations. However, these agreements may be set aside if, among other things, they lead to unconscionable circumstances.

b) Parents and Children

In Canadian law, there is no compendious statement of the duties of parents or the rights of a child. However, the care and upbringing of a child are the responsibility of the child’s parent or custodian. The FLA sets out the duty of the parent to provide support for an unmarried child, as indicated below.

Obligation of parent to support child
31. (1) Every parent has an obligation to provide support for his or her unmarried child who is a minor or is enrolled in a full time program of education, to the extent that the parent is capable of doing so.

Idem
(2) The obligation under subsection (1) does not extend to a child who is sixteen years of age or older and has withdrawn from parental control.

The obligation to provide child support is shared by any parent of a child, and child support takes priority over spousal support obligations. Three limitations to the obligation

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88 S. Fodden, *Family Law* (Toronto: Irwin Law, 1999) at c.12A.
90 There are two cases in which persons are deemed spouses. The first case includes people who have cohabited for at least three years, FLA, s. 29(a). The second include those who have cohabited “in a relationship of some permanence,” if they are the natural or adoptive parents of a child, FLA, s.29(b)
91 FLA, s.53(1)(b).
92 Fodden, supra note 88 at c. 5A(2). To note, Canada ratified the UN Convention on the Rights of a Child on Jan. 26/90.
93 The mother and father of a child are equally entitled to custody and access to their children unless this is altered by the court as part of a separation agreement. This pertains to both married and unmarried parents. Fodden, supra note 88 at c. 3B(2). Also see the *Criminal Code of Canada*, s. 215(1) which establishes that parents, foster parents, guardians or heads of families are under a legal duty to provide the “necessaries of life” to a child under the age of sixteen (and to a spouse or common-law partner or to a person under the parent or guardian’s charge if that person is unable by reason of age, illness mental disorder, etc., to provide himself with the necessaries of life). “Necessaries of life” may include medical aid preserving life. See *R. v. Brooks*, (1902), 5 C.C.C. 372 (B.C.S.C.) cited in E.L. Greenspan, *Martin’s Annual Criminal Code 2001* (Aurora: Canada Law Book, 2001) at 379.
94 A child is the child of his or her natural parents or adopting parents independent of whether the child is born within or outside marriage. A person who has demonstrated a settled intention to treat a child as a child of his or her own family would also be obliged to provide support under FLA, s.31. Hainsworth, supra note 89 at 31-1.
95 Ibid, at 31-1.
exist. First, the obligation lasts only as long as the child is unmarried. Second, the obligation does not extend to a child who is sixteen years of age or older and has withdrawn from parental control. Third, the child must be under the age of eighteen or be enrolled in a full-time education program. If a child is over the age of 18 but enrolled in a full-time program of education, the child is entitled to support. There is no age limitation with respect to students.

Parties have a limited ability to make contracts concerning the care and upbringing of children. For instance, while cohabiting couples may make agreements about their rights and obligations, including the right to direct the education and moral training of their children, they are prohibited from making an agreement about the right to custody or access to their children. Further protection is offered to children under section 56(1) of the FLA, which says that contracts are subject to the best interests of the child. The legislation reflects the notion that children’s interests are best served by having their relations with both parents remain as full as possible and open to change and that parents do not have complete power to bargain away a child’s rights or interests.

c) Other Filial Obligations

No care duties are imposed upon siblings or extended relatives. The philosophy underlying the legislation is that state intervention is an intrusion upon privacy and is justified only by serious dysfunction or breakdown. It is interesting to note, however, that historically filial responsibility legislation can be traced to England’s Poor Relief Act. This act directed the “father, and grandfather, mother and grandmother, and the children of every poor, old, blind, lame and impotent person” to support that poor person to the extent of their ability. The act provided for public assistance only when the recipient could not obtain private family assistance.

d) Intervention

On occasion, society must intervene to prevent harm to children; the formal, legal standard for this lies in the concept of “child in need of protection.” Children’s Aid Societies (CAS), which are quasi-governmental local organizations, are the primary social agents that

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96 Ibid, at 31-4.  
97 Ibid, at 31-4.  
98 Fodden, supra note 88 at c. 1C(2)  
99 FLA, s. 2(10) establishes that a domestic contract takes precedence over the Act, unless the Act provides otherwise.  
100 FLA, s. 53(1)(c ). When parties are separated, they may make agreements relating to custody and access under FLA, s. 54(d).  
101 Courts do not have general supervisory powers over contracts and become involved only in the course of litigation. Fodden, supra note 88 at c. 3C(3)(a)  
102 Any statutory obligations created between relatives with a less direct relationship than that of parent-child would not likely have an effect on family law jurisprudence given that the filial responsibility laws pertaining to adult children and parents is rarely used. See section on “The Elderly” in this paper for further discussion.  
103 Payne, supra note 81.  
104 43 Eliz., ch. 2 (1601).  
protect children.106 Under the Child and Family Services Act107 (CFSA), one of the major responsibilities of a CAS is to provide care for the children assigned or committed to it. Most of CAS’s work is done on a voluntary basis; however, parents may face litigation if they do not accept intervention. The act indicates that removing children from their families is a last resort.108

**The Elderly**

a) Filial Responsibility - Adult Children and Parents

Ontario first adopted a filial responsibility law in 1921 and it survives still today, albeit in a different form. An adult child’s obligation to support parents is determined in part by a “needs-ability to pay test.” That is, a child has an obligation to provide support in accordance with the parent’s needs and to the extent that the child is capable of doing so.109 Current interactions between parent and child or a lack thereof are not a material consideration,110 but the principle of reciprocity applies so that eligible parents are those who themselves had cared for or supported a child.111 The relevant FLA provision is set out below.

**Obligation of child to support parent**

32. Every child who is not a minor has an obligation to provide support, in accordance with need, for his or her parent who has cared for or provided support for the child, to the extent that the child is capable of doing so.

Despite the existence of this provision, actions under this section are very rare.112 In Godwin v. Bolsco113 a 58-year-old mother and widow brought an action against four adult children to pay for her support. The issue at trial was whether the mother had provided care or support to her children that would entitle her to receive financial support from them. After finding that the mother had provided support and as much care as could reasonably be expected of her, the court ordered support payments for the mother to be split amongst the children. The

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106 Fodden, supra note 88 at c.7A.
108 See CFSA s. (1)(2) paragraph 2: “The additional purposes of this Act, so long as they are consistent with the best interests, protection and well being of children, are… 2. To recognize that the least disruptive course of action that is available and is appropriate in a particular case to help a child should be considered.” See also CFSA, s. 57(3) and (4), which limit the court’s ability to remove children from the care of the person who had charge of the child.
109 Hainsworth, supra note 89 at 32-1. This represents a shift away from the earlier Parents-Maintenance Act in which eligibility was based on causes such as destitution, disease, infirmity, and age.
111 Ontario’s Family Law Reform Act of Ontario introduced the principle of reciprocity in 1978. This may have been done because of the higher divorce rate in recent years. J. G. Snell, “Filial Responsibility Laws in Canada: An Historical Study” (1990) 9 Canadian Journal on Aging 268 at 271.
112 Hainsworth, supra note 89 at c. 12A. In Godwin v. Bolsco, infra note 113, the Ontario Court of Justice indicated that the previous Parents’ Maintenance Act, 1921 S.O. 1921, c.52 had “endured for over half a century through several periodic revisions without the slightest contribution to family law jurisprudence.” The court also indicated that the superseding section in the FLA had generated less than a dozen cases. For an explanation / discussion of the low incidence of usage in Canada, see Snell, supra note 111 at 272, who mentions that older dependents receive support voluntarily from children or extended kin without the coercive pressure of the law, that the act is most important in assisting those before pension eligibility, and that the use of the provision may exacerbate intra-familial conflict
definition of “support” was taken from *Black’s Law Dictionary* which noted that support could “… include anything requisite to housing, feeding, clothing, health, proper recreation, vacation, travelling expense, nursing and medical attention in sickness and suitable burial at death.”

The court also acknowledged that while the quality of care might have fallen short of today’s parenting standards, the mother was somehow influential in producing well-educated, sophisticated, productive members of society. The court found that both support and care had been provided, but that the legislation requires support or care, and does not require both.114 The court also ruled that there is no fault-oriented defence unless a parent has failed to care or provide support, but that by analogous application of s. 33(10) of the FLA,115 the court may hear submissions on the quality of care in deciding the amount of support. Finally, the court acknowledged that while parenthood (like marriage) should not be viewed as a basis for a lifetime pension, in certain circumstances the court may order support payments to a parent to continue for an indefinite period.

In *Skrzypacz v. Skrzypacz*116 a mother’s claim for interim support was dismissed because the evidence indicated that the son had been raised by his grandmother. In that case, the test set out in *Goldwin* was reiterated: “What care and support for children would reasonably have been expected in the circumstances in which the family found itself?” These cases make it clear that there is no objective, absolute standard of care and support, but rather, support is context and time specific.

The court has not limited the scope of the obligation of children for parents. In one case the court ruled that the obligations of a child were not secondary to spousal support obligations.117 In another case, the court held that it was not an abuse of process when a spouse commenced proceedings to obtain support from a child.118 However, the court has not allowed expansion of the scope of the obligation to other parties. For instance, the law does not create a right of action in favour of a third party, such as a creditor, to commence proceedings against an adult child.119

b) Legislative Framework and Division of Responsibilities

The most important program allowing the disabled elderly to live independently in the community is community based long-term care.120 The Ontario government introduced the *Long-Term Care Act, 1994*121 (LTCA), which sets out eleven different purposes, among them

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114 This is different from s. 17 of the *Family Law Reform Act*, the predecessor legislation, in which both parental care and the provision of parental support were required to give rise to a child’s obligation.

115 FLA, s.33(10) states: *The obligation to provide support for a spouse or same-sex partner exists without regard to the conduct of either spouse or same-sex partner, but the court may in determining the amount of support have regard to a course of conduct that is so unconscionable as to constitute an obvious and gross repudiation of the relationship.*


119 Hainsworth, supra note 89 at 32-3. See *St. Joseph’s Health Centre v. Sauro* (1984), 45 O.R. (2d) 221, 41 C.P.C. 240 (Co. Ct) where the court held that there was no obligation upon children to pay debts that are incurred by a deceased parent during his lifetime.

120 This section provides only a brief overview of the LTCA.

121 *Long Term Care Act, 1994* S.O. 1994, c. 26. [hereafter LTCA]. Other provincial acts dealing with long-term care in institutions, include the *Nursing Homes Act* R.S.O. 1990 c. N.7, and the *Homes for the Aged and Rest Homes Act*, R.S.O. 1990 c. H.13. Discussion of these acts is beyond the scope of this paper.
“to ensure that a wide range of community services is available to people in their own homes and in other community settings so that alternatives to institutional care exist; to provide support and relief to relatives, friends, neighbours and others who provide care for a person at home.”

The LTCA contains provisions for the Minister to fund and approve community service providers and to impose terms and conditions on the approval and financial assistance.\textsuperscript{123} In addition, the LTCA imposes requirements on approved agencies such as passing and filing of by-laws / documents with the Ministry.\textsuperscript{124} The Minister may also revoke or suspend approval of an agency, or premises given to an agency, or exercise takeover powers.\textsuperscript{125} Complaint and appeal processes are also set out in the LTCA.\textsuperscript{126} Approved agencies must establish processes for reviewing complaints and responding within 60 days.\textsuperscript{127}

In January 1998, Ontario moved to a single-point of entry to the long-term care system (including home and facility-based care) by establishing 43 Community Care Access Centres (CCACs), which are the single intermediary responsible for purchasing services for consumers.\textsuperscript{128} CCACs are non-profit corporations. They manage all community services within their geographic area by assessing service needs within their area, referring clients for facility placements and purchasing homemaking and professional services on a competitive basis\textsuperscript{129} from for-profit and not-for-profit providers within capped budgets set by the province.\textsuperscript{130} CCACs are run by volunteer boards and have little or no direct responsibility for these services. Instead, CCACs manage competition between providers, which are selected based on cost as well as quality, innovation and diversity. CCACs do not depend on single organizations. This system is designed to promote the flexibility, innovation, efficiency and responsiveness seen to flow from competition while assuring accountability for public money.\textsuperscript{131}

A couple of assumptions underlie the general shift from institutional to community-based care in Ontario. The first assumption is that services can be provided more cheaply in the community than in institutions. The second is the belief that consumer choice, independence and quality of life improve when services are provided closer to home. It is important to note, though, that community services are not subject to the requirements set out in the CHA. Comprehensive coverage of even medically necessary care is not required under the CHA when care is delivered outside of hospitals by providers other than physicians. While

\textsuperscript{122} See LTCA, s. 1.
\textsuperscript{123} See LTCA, Part IV.
\textsuperscript{124} See LTCA, Part VII.
\textsuperscript{125} See LTCA, Part X for the Minister’s powers of revocation and take-over.
\textsuperscript{126} See LTCA, Part IX.
\textsuperscript{127} See LTCA, s. 39.
\textsuperscript{128} J. Gray, “Home Care in Ontario: The Case for Copayments” (2000) 8 Health Law Journal 177 at 180. CCACs provide information and referral to all long-term care services, plan and monitor home care services, provide case management and co-ordinate client placements.
\textsuperscript{129} The principle manner in which CCACs purchase services is through Request for Proposals (RFPs).
\textsuperscript{130} A.P. Williams, J. Barnsley, S. Leggat et. al., “Long-Term Care Goes to Market: Managed Competition and Ontario’s Reform of Community-Based Services” (1999) 18 Canadian Journal on Aging 125 at 132. [hereafter Williams et. al.]
this allows the provincial government a great deal of flexibility in deciding which services will be covered in the public system, the complexity of the community based sector makes it difficult to define and measure service quality. No governmental body is responsible for auditing performance or clarifying standards. Instead, individual CCACs are responsible for monitoring quality. Although Canada has historically been reluctant to micro manage (e.g., the CHA deals only with issues of access and equality, leaving quality to be addressed at the point of delivery), the CCAC system allows for-profit providers. Under previous systems, quality could presumably be addressed by professionals with expert knowledge and altruistic models.\textsuperscript{132} In addition, services provided in geographically dispersed settings, including the consumer’s home, make peer review and direct supervision difficult.\textsuperscript{133} Consequently, it has been suggested that CCACs should be required to provide a minimum level of services as mandated by the provincial government.\textsuperscript{134}

c) Benefits

The LTCA includes a patient’s bill of rights,\textsuperscript{135} which sets out the rights of recipients with respect to service providers.\textsuperscript{136} Recipient rights include the right to be dealt with in a manner that is courteous, respectful and free from abuse; that respects dignity and privacy, and promotes autonomy; recognises individuality; and is sensitive and responds to needs and personal preferences. In addition, recipients have the right to information about the community services provided and to be told who will be providing the services; participate in the assessment and development of the personal plan of service;\textsuperscript{137} give or refuse consent; raise concerns or recommend changes; be informed about the laws, rules and policies affecting the operation of the service provider and be informed in writing about the complaint procedure; and have records kept confidential. An approved agency must give notice of these rights.\textsuperscript{138} Community services include community support, homemaking, personal support and professional support services:

- Community Support Services – meals, transportation, caregiver support adult day programs, home maintenance, security checks, social or recreational services, etc.
- Homemaking Services – housecleaning, laundry, ironing, banking, shopping, meal preparation, bill payments, etc.
- Personal Support Services – personal hygiene activities, routine personal activities of living, etc.
- Professional Support Services – nursing, occupational therapy, social work, dietetics, etc.\textsuperscript{139}

As indicated previously, coverage of these services is not required under the CHA.\textsuperscript{140} Ontario CCACs impose no co-payments or fees and do not have a formal income assessment

\textsuperscript{132} Williams et al., supra note 130 at 135, argue for the need for more formal mechanisms to protect quality.
\textsuperscript{133} Ibid, at 126-27.
\textsuperscript{134} See Williams et al., supra note 130 at 139.
\textsuperscript{135} LTCA, s. 3(1).
\textsuperscript{136} “Service Provider” is defined in s. 2 as including an approved agency, a person providing community service purchased by an approved agency, the Minister if providing community service or establishing /operating /maintaining facilities for the provision of community service, and a person providing community service with the support of payment, financial assistance, grant or contribution etc.
\textsuperscript{137} Under LTCA, s. 22, when a person applies to an approved agency for community services, the agency must assess requirements, determine eligibility and develop a plan of service that sets out the amount of each service to be provided.
\textsuperscript{138} See LTCA, s. 25.
\textsuperscript{139} For complete definitions, see LTCA, s. 2(3)-(7).
program or a policy to support low-income clients.\textsuperscript{141} CCAC case managers assess needs and eligibility, but there is no uniform assessment tool yet, nor are case managers held to any legislative standard.\textsuperscript{142} Ontario imposes limits on the number of hours and the costs of nursing and other supports, and accessibility to the home support package is subject to the availability of funds from the yearly budget.\textsuperscript{143}

d) Support Provided to Caregivers

A recent report by Statistics Canada indicates that the vast majority of elderly receive informal assistance of some type or form.\textsuperscript{144} Another study notes that informal caregivers are responsible for 80-90\% of the assistance provided to the elderly in their homes.\textsuperscript{145} Finally, a recent study found that 15\% of Canadians provided care in the home, and amongst those people, the average time commitment was 21 hours a week.\textsuperscript{146}

Indirect financial support is available in Canada through the tax system, in the form of tax credits. A tax credit compensates a taxpayer for the costs of providing care or purchasing care-related services by enabling an amount to be deducted from taxes owed.\textsuperscript{147}

\textit{Guardianship}

In Ontario, guardianship is affected by more than one piece of legislation; relevant laws include the \textit{Substitute Decision Act, 1992 (SDA)}\textsuperscript{148} and the \textit{Health Care Consent Act, 1996 (HCCA)}.\textsuperscript{149} The SDA covers both property and personal care decision making, while the HCCA covers medical treatment decisions and decisions about admission to care facilities and personal assistance services.\textsuperscript{150}

Ontario’s guardianship laws were reformed in the 1990’s. The reform included embedding the common law presumption of competence in the new legislation.\textsuperscript{151} The significance of this presumption includes that it encourages respect for elderly rights: age alone is not considered to render one incompetent. Specific procedures and requirements outlined in

\textsuperscript{140} Williams et. al., supra note 130 at 132. Only professional services and basic homemaking services at the standard ward level need to be covered even in hospitals. Williams et. al., supra note 130 at 132.

\textsuperscript{141} Gray, supra note 128 at 179-80.

\textsuperscript{142} The LTCA does not regulate the CCAC’s decisions. Gray, supra note 128 at 181.

\textsuperscript{143} If the home care budget runs out, no services are provided. Ibid at 180-181.

\textsuperscript{144} See \textit{Eldercare in Canada: Context, Content and Consequences} (Ottawa: Statistics Canada, 1999).


\textsuperscript{146} A Price Waterhouse Cooper study cited in Gray, supra note 128 at 184. Statistics Canada noted a 100\% increase in recent years in absenteeism for personal or family reasons; 37\% of that increase is attributable to time spent caring for an elderly relative. A. Martin-Matthews, “Canada and the Changing Profile of Health and Social Services: Implications for Employment and Caregiving” in \textit{Working and Caring}, supra note 2 at 13.

\textsuperscript{147} Keefe & Fancey, supra note 145 at 196. See this article for more details.

\textsuperscript{148} S.O. 1992, c. 30. [hereafter SDA]

\textsuperscript{149} S.O. c.2 Sched. A. [hereinafter HCCA]

\textsuperscript{150} The \textit{Advocacy Act}, S.O. 1992, c. 28 which provided advocacy and rights advice, was repealed in 1995 by the Conservative Government.

\textsuperscript{151} Doron, supra note 5 at 82. For instance, see the SDA., s. 2(2) concerning capacity with respect to personal care which states: “A person who is sixteen years of age or more is presumed to be capable of giving or refusing consent in connection with his or her own personal care.” Under the HCCA, there is no minimum age; s.4(2) states: “A person is presumed to be capable with respect to treatment, admission to a care facility and personal assistance services.”
the legislation must be followed to change a person’s competence status.\textsuperscript{152} Further, in the new system appointing a guardian is a last resort.\textsuperscript{153} The definition of incapacity for personal care under the SDA is set out below.

\textit{Incapacity for personal care}

45. A person is incapable of personal care if the person is not able to understand information that is relevant to making a decision concerning his or her own health care, nutrition, shelter, clothing, hygiene or safety, or is not able to appreciate the reasonably foreseeable consequences of a decision or lack of decision.\textsuperscript{154}

Thus the definition is a cognitive\textsuperscript{155} one based on ability to understand relevant information and reasonably foreseeable consequences. A distinction is drawn between mental illness and mental incapacity: the former does not automatically result in the latter, and the latter does not imply anything about the former. In this way, elderly people cannot be assumed to be mentally ill simply because of legal incapacity. The reform also replaced the term “incompetence” with “incapacity.” The term incompetence is more of a global notion suggesting deteriorated mental condition leading to an absence of capacity for all tasks.\textsuperscript{156} Incapacity, on the other hand, is a more restricted notion and is not a global determination of broad mental ability. It recognizes abilities can be lost in part rather than as a whole, and is evaluated in relation to the nature and complexity of an issue.\textsuperscript{157} The guardianship system, however, is still binary. A person is either legally capable or not. If a person is found mentally incapable, the person loses legal rights and is subordinated to the control of the guardian in the areas of incapacity.\textsuperscript{158}

The system, however, allows for alternatives to guardianship such as advance directives. Advance directives are an umbrella tool covering various individual legal tools for planning ahead and anticipating needs. These legal tools are prepared by a person prior to incapacity, so that the person may control the legal decisions made on his or her behalf.\textsuperscript{159} The SDA provides that a person may give a written power of attorney for personal care authorising the attorney to make decisions about the grantor’s personal care.\textsuperscript{160} The HCCA sets out a prioritised list of who may give consent on behalf of the patient with respect to treatment and admission to a care facility. This list gives precedence to an incapable person’s guardian, followed by the person’s attorney for personal care and the representative appointed by the Consent and Capacity Board. The list of substitute decision makers ends with a prioritised list of family and other members.\textsuperscript{161} In addition, a “trustee” can be appointed for some federal and provincial programs without resorting to formal guardianship. For example, benefits paid under

\begin{footnotes}
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\item 152 Doron, supra note 5 at 82.
\item 153 SDA, s. 55(2).
\item 154 See HCCA, s. 4 for a similar definition with respect to treatment, admission to a care facility or eligibility for personal assistance services.
\item 156 Doron, supra note 5 at 86.
\item 157 Ibid.
\item 158 Ibid at 88.
\item 159 A person may authorise a proxy, an agent to make decisions on his or her behalf, or provide instructions about what decisions should be made, or do both.
\item 160 SDA, s. 46. See also HCCA, s. 5 for wishes for treatment, admission to a care facility or personal assistance services expressed while capable (including wishes in the form of a power of attorney).
\item 161 See HCCA, s. 20 for example.
\end{footnotes}
old age security and disability programs have provisions allowing the appointment of a trustee to manage the payments of a recipient who is unable to do so.\textsuperscript{162} There are also other mechanisms such as joint bank accounts and joint ownership of property that may avoid or delay formal guardianship.

**The U.S.**

**Background**

a) Legal System

America has a common law system. The system is divided between federal and state levels, and both levels have executive, judicial and legislative institutions.

b) Demographics

The United States has a population of 280.3 million people;\textsuperscript{163} 16\% of the population are aged 60 or older and 22\% are under the age of 15.\textsuperscript{164} The percentage of the state population that is 65 years or older varies from 3.1\%-17.6\%\textsuperscript{165} with Maryland falling in between at 10.3\%.\textsuperscript{166} The United States has one of the most socially, ethnically and economically diverse populations in the world.

c) Ideology underlying Health Care

Despite its wealth and high standard of living, America has lagged behind other countries in developing a comprehensive and integrated long-term care system.\textsuperscript{167} Two major publicly funded health care programs, Medicare and Medicaid, are the largest government programs involved in long-term care.\textsuperscript{168} Private long-term care health insurance is virtually unavailable.\textsuperscript{169}

d) Division of Responsibilities

Medicare is a federally administered national health insurance program under the *Social Security Act* offering medical care benefits to those aged 65 years and older, and to disabled people under the age of 65. There are uniform eligibility requirements, and coverage is available to most over the age of 65. Reducing financial exposure with respect to medical care and increasing accessibility were the primary objectives of the Medicare program.\textsuperscript{170}

\textsuperscript{162} See the *Old Age Security Act*, R.S.C. 1985, c. O-9, s.34(0); *Canada Pension Plan Act*, R.S.C. 1985, c. P-6 s. 89(1)(d); *Ontario Disability Support Program Act*, R.S.O. 1997, c. 25, s. 12(1)(2) referred to in Doron, supra note 5 at 197.

\textsuperscript{163} UN demographic, supra note 21 at 164.

\textsuperscript{164} World Populations, supra note 22.

\textsuperscript{165} T. Jazwiecki, “Long-Term Care for the Elderly in the United States” in *Aging World*, supra note 3 at 290-91.

\textsuperscript{166} Ibid, at 293.

\textsuperscript{167} Ibid, at 288.

\textsuperscript{168} Ibid, at 300.

\textsuperscript{169} Ibid, at 289.

\textsuperscript{170} Ibid, at 300.
Medicaid, which is also under the Social Security Act, is a state administered medical assistance program for the poor and the needy funded jointly by state and federal governments. It is the major source of financing for long-term care for the elderly and for the non-elderly disabled. Although there are broad federal guidelines, at the state level coverage, eligibility and administration vary.

The Elderly

a) Filial Responsibility – Adult Children and Parents

Twenty-eight states have filial support laws, but their use is rare or non-existent. There has been a wane in public support for the concept, as evidenced by a growing reluctance of district attorneys to prosecute violations, an increase in constitutional attacks on filial support laws, and a decline in the number of states that have filial responsibility laws.

Maryland is one of the states with a filial responsibility statute: an adult child has a duty to provide food, shelter, care and clothing to a “destitute parent,” i.e., one who cannot be self-supporting because of mental or physical infirmity. Breaking this law is a criminal offence, but in practice as in the rest of the country, there is very little use of the statute.

b) Benefits

The U.S. has no national community-based long-term care program, but as mentioned previously, Medicare and Medicaid deal with some dimensions of long-term care. Both Medicare and Medicaid cover hospital care and physician and allied health professional services. Medicaid also covers services often excluded from Medicare and private insurance. To illustrate, while Medicare does not pay for prescription drugs and pays for only a limited amount of home care and nursing home care, Medicaid pays for all three.

As the long-term care protections of Medicaid are focused on those with low-income and are limited reach, many individuals with long-term care needs and their informal caregivers often face substantial financial burden. Individuals who qualify for Medicaid must contribute all of their monthly income to the cost of care except for a small personal needs allowance. The availability of in-home services is restricted to home health services or skilled nursing and therapy and does not include non-medical support.

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172 Federal regulations require Medicaid to cover certain mandatory services including home-health services and skilled nursing facility services for the elderly.

173 Narayanan, supra note 105 at 375. This author indicates that it is only recently that have American states failed to enforce filial responsibility laws. In the 1930’s to 1950’s, courts held many adult children legally responsible for their elderly parents.


175 To note, states are prohibited from requiring adult children to contribute to the cost of nursing home care as a condition for Medicaid eligibility. Social Security Act § 1902(a)(17)(D) referenced in Doron, supra note 5 at 312.


177 Kaiser Commission, supra note 171.
In Maryland the majority of non-medical in-home care is not covered by government or state programs.\textsuperscript{178} However, in Maryland’s various departments and agencies there are programs such as daily meals, adult day care, transportation, assistive living, and pharmacy assistance.

c) Support Provided to Caregivers

In the U.S., the majority of adult children live within 100 miles of their elderly parents. Most adult children see their parents regularly and make financial contributions to them.\textsuperscript{179} Between 70-80\% of all long-term care services are provided by informal caregivers such as family members and friends.\textsuperscript{180} One study has estimated that the national economic value of informal caregiving was $196 billion in 1997.\textsuperscript{181}

The federal \textit{Family Medical Leave Act} (FMLA) includes elder care leave. In recognition of the fact that most women with families work, the legislation is designed to protect families from the loss of a breadwinner’s job when compelling family needs arise.\textsuperscript{182} (The act also includes men in the definition of caregiver, acknowledging the need and desire for men to play a role in caregiving.) Under the legislation, a worker can take up to twelve weeks of unpaid leave per year in circumstances that are critical to the life of a family. These circumstances are (a) the birth of a child, with the need to care for the child; (b) the placement of a child with the employer for adoption or foster care; (c) the need to care for a spouse, son, daughter, or parent of the employee if the relative has a serious health condition; and (d) a serious health condition that makes the employee unable to perform the functions of the employee’s position.\textsuperscript{183} The act applies to private sector employers only if they have 50 or more employees. All public agencies are included. Eligibility is determined when the employee requests leave.\textsuperscript{184} Of note, more than 50\% of states have their own family leave statutes and most of the guarantees are substantially similar to those of the FMLA.\textsuperscript{185}

While there is no federal provision for compensation to paid caregivers, in 69\% of states and jurisdictions, some form of financial payment is possible. Such payments are usually restricted to family caregivers for elders who are at high risk of institutionalisation and who qualify for Medicaid or other means-tested forms of assistance.\textsuperscript{186} There are also tax supports in

\textsuperscript{178} M.B. Kapp, “Enhancing Autonomy and Choice in Selecting and Directing Long Term Care Services” (1996) 4 Elder Law Journal 55 at 60-61 cited in Doron, supra note 5 at 315.
\textsuperscript{179} Narayanan, supra note 105 at 369.
\textsuperscript{180} Jazwiecki, supra note 165 at 325.
\textsuperscript{181} P.S. Arno, C. Levine & M.M. Memmott, “The Economic Value of Informal Caregiving” (1999) 18 Health Affairs 182. The article points out that the economic value of informal caregiving is generally not acknowledged because it lies outside the market economy.
\textsuperscript{183} E. A. Hayes “Bridging the Gap Between Work and Family: Accomplishing the Goals of the Family and Medical Leave Act of 1993” (2001) 42 Wm and Mary L. Rev. 1507.
\textsuperscript{184} Ibid.
\textsuperscript{185} Ibid.
\textsuperscript{186} “Mix of Public and Private”, supra note 176 at 124. Many states exclude certain kin (such as spouses, adult children or siblings, and grandchildren) from receiving compensation. Several states will pay only if the recipient and caregiver do not reside together. Also, some programs require the caregiver to give up outside employment. Some states have respite care or day care services to prevent exhaustion of family members.
the U.S. The Federal Dependent Care Tax Credit\footnote{In addition, about 50\% of states offer a dependent tax care credit and the majority of these follow the federal credit format of covering children and other dependents. There is much interstate variation in eligibility and scope of coverage. Keefe & Fancey, supra note 145 at 197.} covers expenses incurred for the care of elderly dependents (and children and the disabled) that are incapable of self-care for whom the taxpayer maintains a household.\footnote{Ibid, at 196.} Support must be extensive enough to qualify the elderly parent as a dependent. (A dependent is a relative who receives more than 50\% of support from the taxpayer). If the taxpayer is married, both spouses must be employed or seeking gainful employment.\footnote{Ibid.} In addition, the Dependent Care Assistance Plan (DCAP) allows employees to exclude from their taxable income up to $5,000 of their elder care expenses. The DCAP is available only to employees whose employers have set up such a plan. Employers do not pay social security or employment taxes on employee DCAP contributions. The tax credit and the DCAP can be used simultaneously, but the same expenditures cannot be claimed twice.\footnote{“Mix of Public and Private”, supra note 176 at 122.}

Both these tax programs are subject to government restrictions, which limit their use. For example, both tax plans require employees to spend eight hours a day with the elder, i.e., essentially live with the recipient. In reality, only 15\% of non-spouse caregivers fit this category.\footnote{U.S. Bureau of the Census, U.S. Department of Commerce, (1995) \textit{Statistical abstract of the United States:1995} (115\textsuperscript{th} ed.). Washington, DC: U.S. Government Printing Office cited in “Mix of Public and Private”, supra note 176 at 122.} DCAPs further require that the employee pays a minimum of 51\% of the elder’s care-related expenses, which naturally excludes many caregivers.\footnote{A. Costello (1996). Dependent care programs. In J.S. Rosenbloom (Ed.), \textit{The handbook of employee benefits: Design, funding and administration} (4\textsuperscript{th} ed.) (Chicago: Irwin pp. 401-411) cited in “Mix of Public and Private”, supra note 176 at 122.}

\textbf{Guardianship}

In 1997, Maryland reformed its guardianship laws. Four elements of the guardianship system are relevant here. First, Maryland’s standard for incapacity requires clear evidence that a person lacks cognitive ability. The definition of incapacity is that a person “lacks sufficient understanding or capacity to make or communicate responsible decisions.”\footnote{Md. Stat. Ann. §13-705(b) as cited in Doron, supra note 5 as cited in Doron, supra note 5 at 307.} Second, guardianship is a tool of last resort and can only be used if “no less restrictive form of intervention is available.”\footnote{Md. Stat. Ann. §13-705 (d) and (e) as cited in Doron, supra note 5 at 307.} Third, there are strict due process protections: an attorney must be appointed for a person subject to guardianship proceedings, and the subject of guardianship proceedings must be present at a court hearing unless he/she has knowingly and voluntarily waved the right.\footnote{Md. Stat. Ann. §13-706 and §13-708 as cited in Doron, supra note 5 at 307.} Finally, full-scale guardianship has been done away with. The court can grant the guardian only the powers necessary to provide for the demonstrated need. Appointment of a guardian does not indicate general incompetence or modify civil rights unless the court so orders.\footnote{Md. Stat. Ann. §13-705(b) as cited in Doron, supra note 5 at 306.}

In conjunction with federal laws, Maryland’s laws offer almost all the legal alternatives to guardianship including living wills, advance directives, durable powers of attorney, trusts,
joint ownership and estate planning. In the field of medical treatment, surrogate decision-making is accepted. Once a person is certified as incapable of making informed medical decisions, consent to treatment is given by individuals on a hierarchical list, which commences with the formal guardian, followed by various relatives and others who meet specified conditions.

**DISCUSSION**

While all three jurisdictions are developed and western nations, the level of support services varies. At one end, Sweden has fairly comprehensive long-term care services, as well as support for caregivers in the form of paid leaves and payments to informal caregivers. At the other end, the U.S. has no government funded universal health care plan, limited long-term care services, no paid leaves and limited financial support to informal caregivers.

One author has suggested that a number of factors account for the difference in social support amongst “rich” countries. States with the most comprehensive and affordable support tend to have amongst others the following characteristics: strong unions, more centralised governments, more developed public social welfare systems (i.e., universal health care), less developed private sector initiatives and more homogeneous populations. Sweden has all of these characteristics. For example, 90% of the labour force is unionised, the country engages in central planning, the private sector is very small and the population has historically been quite homogeneous. By contrast, the United States has none of these characteristics. Only 15% of the labour force is unionised, there is decentralised political power amongst major institutions such as the government, business community, interest groups, the private sector is more prevalent in long-term care than in any other developed nation and the population is ethnically diverse. Canada falls somewhere in between: about one-third of the workforce is unionised, private sector initiatives are somewhat developed, but public support is still present and Canada’s population is multi-cultural.

*Spouses, Parents and Children*

In Sweden and Canada, spouses have an obligation to support each other within limits. The limits are based on the ability of one spouse and the need of the other. Thus, the language of the legislation is similar to Marx’s statement: “From each according to his abilities, to each according to his needs,” reflecting the socialist leaning of the legislation.

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197 Doron, supra note 5 at 307-308.
199 V.M. Lechner, “Final Thoughts” in Working and Caring, supra note 2 at 227, [hereafter “Final Thoughts”]
200 H. Wilensky, The welfare state and equality: Structural and ideological roots of public expenditures. (Berkeley: University of California Press, 1975) cited in “Final Thoughts”, supra note 199 at 227. The other factors cited are: meagre self-employment experiences, a middle class without the perception that its tax burden is unfair in relation to the rich and upper middle class and citizens who do not feel a large social distance from the poor.
201 This decentralization of power makes it difficult for a government to develop coherent policies that provide long-term care services for all, paid family leaves or other family-focused benefits. “Final Thoughts”, supra note 199 at 228.
202 See “Final Thoughts”, supra note 199 at 227-228 for further discussion.
With respect to parental obligations to care for a child, however, the legislation in the two jurisdictions differs. In Sweden, the obligation to support a child ends when the child reaches age 21. Children engaged in full-time study beyond the age of 21, or who because of illness or similar reasons cannot make their own living have to rely upon grants, other economic assistance from the community, or social insurance benefits. In Ontario there is no age limit for a child enrolled in a full-time program of education. Parents continue to be responsible for support to the extent that they are capable. The Swedish system reflects the government’s acceptance of a major role in the lives of its people while in Canada the burden of support is shifted to the private institution of the family.

When children need protection, Sweden and Ontario both have mechanisms for state intervention. These mechanisms are similar: care is often provided on a voluntary basis with the consent of the parents, but there are mechanisms to remove a child without consent. In both jurisdictions, removing children from the home is a last resort. However, unlike in Sweden, the current legislation in Ontario promotes minimal intervention. Under earlier legislation, a “child in need of protection” was defined more broadly and vaguely, reflecting the view that Children Aid Societies should not be frustrated in efforts to help children.\(^\text{204}\) In one case, the Supreme Court of Canada, the highest court in the country, called the current Ontario legislation one of the “least interventionist regimes.”\(^\text{205}\)

**The Elderly**

Although all three countries have growing elderly populations, they have formulated different policies in regard to filial and state responsibility for care. At one point, Sweden, the U.S. and Canada all had filial responsibility laws. While Sweden has repealed its law, Ontario and some American states have chosen to maintain theirs in some form. The retention reflects the belief that care is primarily a family responsibility. In this way the public purse is protected from the burden of supporting people who have families able to provide support.

Given the systems of Ontario and Maryland differ from that of Sweden, it may be useful to review the arguments for and against filial responsibility laws.\(^\text{206}\) Proponents argue that these laws reduce public welfare costs and deter reliance on public assistance. Proponents also argue that legal recognition of familial duties encourages the maintenance of relationships, and a positive family environment affirms autonomy while meeting needs. That is, dialogue about duties clarifies expectations and positions, promoting autonomy and healthy relationships. Opponents suggest, however, that the level of assistance provided by relatives is below that offered by public assistance and thus groups who live below subsistence levels are created. In addition, opponents suggest that a relationship stemming from the coercive pressure of the law can result in strain instead of support and can compromise independence since the family often has access to or controls mail, calls, visitors, professional appointments, etc. Finally, opponents argue that filial responsibility legislation imposes an economic burden on those least able to afford it, thereby perpetuating a cycle of poverty. The adult children who oppose such legislation are usually tied to their elderly parents by the common bond of

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\(^\text{204}\) Earlier definitions were based on the word “proper” such as “care properly”, “improper place,” etc. See *Child Welfare Act*, R.S.O. 1980, c. 66 s. 19(1). There were also fewer procedural safeguards ensuring child and parent participation in the process. Fodden, supra note 88 at ch. 7(A).

\(^\text{205}\) *Catholic Children’s Aid Society of Metropolitan Toronto v. M. (C)*, [1994] 2 S.C.R. 165 at 191 cited in Fodden, supra note 88 at ch. 7(A). To note, there are pressures to amend the legislation to ensure that the interests of children are paramount, not the interests of families.

\(^\text{206}\) These are taken from Narayanan, supra note 105 at 378-379.
poverty. Caregivers often experience stress and exhaustion. This may exacerbate family impoverishment and destabilisation and make it necessary to increase the use of health care resources for the caregiver and the patient. From a feminist perspective, then, encouraging or supporting the provision of care by family members may be viewed as perpetuating a sexually oppressive feature of traditional family life, which imposes care burdens upon women.

Filial support can perhaps be better achieved in a way other than through direct imposition of responsibility. The chances that families will meet their financial and caring responsibilities are increased by policies that promote closer social relationships such as paid leaves of absences from work. Initiatives with a greater financial impact are often most useful in alleviating the burden of supporting elderly parents.

Support for Family and Informal Caregivers

Paid Caregiving

The three jurisdictions offer different levels of support in the form of paid caregiving in line with the continuing debate in the international literature about providing care allowances. Some of the drawbacks of a paid caregiver system include that: the amount of money involved usually renders it more a compensation (allowance) than payment for work done; there are no certified unions examining pay scales and work conditions; and there are differences between those who use such programs and those who do not. Users of the programs often are non-urban, and they live in areas where services are scarce and unemployment is high. In this way, the program may reinforce disparities in society.

Leave from Employment

Both Sweden and the U.S. have legislation that provides support to caregivers in the form of leaves. The provisions in the two jurisdictions, however, are very different. One of the greatest differences is that in the U.S. these leaves are unpaid, making them difficult if not impossible for those with little financial flexibility. Working class parents are less likely than their middle and upper class counterparts to be able to afford to take an unpaid leave. While the act allows for the substitution of paid for unpaid leave, employees with the lowest paid jobs are least likely to have generous benefit packages. Unpaid leave is only a first step, then, towards reconciling the competing needs of work and family. Income replacement is necessary for workers to have meaningful access to the leave.

207 Arno, Levine & Memmott, supra note 181 at 186.
208 This holds true even in Sweden where equality concerns are paramount.
209 Doron, supra note 5 at 222. Doron goes on to argue that morally legitimate policies would be sexually neutral or reduce the burden of care. The challenge is not so much formal equality but actual implementation. A better policy would be based on publicly funded modes of care outside the traditional family boundaries, coupled with education about the role of men in caring. See Doron, supra note 5 at 222-223.
210 Narayanan, supra note 105 at 405.
212 Hayes, supra note 183 at 1523.
213 Ibid, at 1524.
214 Lenhoff and Becker, supra note 182 at 439.
The U.S. legislation is also problematic in other ways. The legislation pertains only to “family members” defined as sons, daughters and parents.\(^{215}\) This does not necessarily reflect the realities of caregiving, which may be offered by other kin such as siblings, grandchildren, nieces, nephews, or even non-family, friends or neighbours. The amount of time granted for leave in the U.S. is also an issue because it is often insufficient to care for a sick elderly person.\(^{216}\) In addition, the U.S. legislation states that intermittent leave or leave on a reduced schedule can be taken for the care of a child, spouse or parent or because of a serious health condition, but only when it is medically necessary.\(^{217}\) Finally, the legal trigger set out in the U.S. legislation is “serious health condition”. This is defined as an illness, injury, impairment or physical or mental condition that involves: (a) inpatient care in a hospital, hospice or residential medical care facility; or (b) continuing treatment by a health care provider.\(^{218}\) This definition may not be appropriate for the elderly since long-term care for these people is generally needed because of chronic illness coupled with gradual loss of memory or functional capabilities, not a temporary emergency like broken bones or imminent danger.\(^{219}\)

**Tax Policies**

Tax policies are a governmental tool that reflects government values and preferences and can shape behaviour. From an administrative perspective, tax relief is simpler and costs less than implementation of direct services.\(^{220}\) Some authors, however, argue that supporting family caregivers through the tax system does not result in significant assistance.\(^{221}\) While tax credits may strengthen or stimulate informal care provision, a time lag exists. The delay in relief may mean that the tax system is ineffective in targeting cases in which a risk of institutionalisation exists.\(^{222}\) In addition, the tax incentives are minimal in both countries and are not generally reflective of the actual amount spent by caregivers providing care in the home. Finally, the strict eligibility criteria often attached to such credits render them unusable by the majority of caregivers.

Direct forms of compensation, such as those offered in Sweden, are likely to be more useful, suitable and equitable to the caregiver. Some have argued, though, that support to family members should take second priority to support offered directly to those needing care. Rather than supporting family caregivers, it may be more appropriate if the goal of policy becomes supporting those in need of care.

**Guardianship**

All three jurisdictions have some form of guardianship, but there are some differences between them. All three systems have addressed due process protections; avoid total

\(^{215}\) However, those family members are defined broadly. For instance, “son” or “daughter” is defined to include biological, adopted, step or foster child, legal ward, or a child of a person standing in loco parentis, who is under 18, or 18 and older if incapable of self care because of physical or mental disability. See 29 USCS §2611 (2001).

\(^{216}\) This criticism may also be levied against the Swedish system.

\(^{217}\) See 29 USCS §2612(b) (2001).

\(^{218}\) 29 USCS §2611 (11) (2001). The term “health care provider” is defined as a doctor of medicine or osteopathy who is authorised to practice medicine or surgery (as appropriate) by the State in which the doctor practices; or any other person determined by the Secretary to be capable of providing health care services. See 29 USCS §2611(6) (2001).

\(^{219}\) Doron, supra note 5 at 206.

\(^{220}\) Keefe & Fancey, supra note 145 at 203.

\(^{221}\) See Keefe & Fancey, supra note 145 at 201.

\(^{222}\) Ibid, at 201.
guardianship; implement guardianship in a tailored and flexible fashion; recognise guardianship as a last resort and the need to preserve the rights and status of the elderly; and have alternatives to guardianship. However, the Ontario and Maryland systems are more individual oriented. For example, both jurisdictions give significant weight to advance directives in their approach to alternatives for elder guardianship.\textsuperscript{222} By contrast, advance directives in Sweden do not play an explicit role and are not specifically addressed in legislation. Some Swedish scholars, however, argue that formal recognition of advance directives for health care is part of the larger requirement of affording respect to individual persons. Consequently, there is likely to be continued debate and perhaps a parliamentary investigation into the role of advance directives in Sweden.\textsuperscript{224} This may be a first step towards increasing the prominence of the role of the individual, and therefore a step towards the personal autonomy and individual rights orientation of Canada and the U.S. in this context.

**CONCLUSION: COMMENTS ON THE FUTURE**

As of 1999, there were no immediate plans for significant changes to the care of the elderly in Sweden.\textsuperscript{225} The increasing strain on Sweden’s public purse, which is due in part to the ageing population and the earlier economic downturn (particularly harsh from 1991 to 1996), however, may have implications for the current system. It should be acknowledged, though, that the major result of the poor economy was an increase in the division of wealth and income while the structure of the welfare model has remained intact.\textsuperscript{226}

One author argued that the changes in welfare policies on ageing which have occurred, including a decrease in access to services, were minor adaptations made to sustain and protect the model. This author suggests that lack of change in a changing society would suggest rigidity. The author speculates, though, whether the trends indicate a shift towards the model of the United States.\textsuperscript{227} One factor contributing to this shift may be the increasing pluralism and heterogeneity of Sweden’s population. The benevolent state may be dependent on a homogeneous population. As heterogeneous groups segment the population, solidarity may decrease and support for collective solutions may weaken.\textsuperscript{228}

Three possible scenarios for the long-run have been identified: (1) continuation of the current system in which the public sector provides more than 90\% of elder care and private care remains a phenomenon of urban areas; (2) a larger private sector role and increased inequality due to decreased allocation of funding and public spending in general; and (3) increased competition amongst care providers with a larger role of publicly financed but private care providers. Which scenario emerges will depend on the ideology of the political party in power, but the most likely development in Sweden is a combination of the first and

\textsuperscript{223} The economic dimension is also worthy of consideration in the sense that costs of advance directives rest on the individual and the focus on advance directives may be viewed as a privatising tool, which transfers the duty from the public to the private sphere.

\textsuperscript{224} There has been lively debate in Sweden as to whether advanced directives concerning health care ought to be respected. Professor Elisabeth Rynning, Upsala University, Sweden. (Telephone Conversation 2002-03-06).

\textsuperscript{225} Andersson, supra note 51 at 113.


\textsuperscript{227} Ibid.

\textsuperscript{228} Ibid.
third scenarios. With the autonomous positions of the municipalities and their varying political ideologies, there will inevitably be greater disparities in the organization of elder care.  

Similar to the Swedish system, Canada faces challenges in the future. As the baby boomer population ages, there will be a corresponding increase in demand for limited health care resources and a greater strain on the public purse. One projection suggests that the labour force dependency ratio will increase to 1.6 or 1.7 by 2036. This means that for every 160-170 people outside the labour force, only 100 people will be in it. In the search for solutions, an evaluation of state and individual responsibilities and the role of the private sector will likely ensue.  

While in most Canadian provinces, filial responsibility laws exist establishing a statutory obligation of adult children to support parents under certain circumstances, this obligation has not had much impact in reality. Given the inevitable increase in demand, government support of the economically vulnerable may erode and responsibility for care may shift even more towards the family. The future may witness an increased reliance on filial responsibility legislation in order to protect the public pocket. Greater harmonization of family responsibilities and paid employment would allow for more equal treatment for workers with dependents requiring care and those without them.  

In the future the United States is also likely to witness a rising demand for informal caregivers while the actual supply decreases. Several factors point to the likelihood of this. Pressures related to demographic and social trends include gains in longevity with the most rapid growth being amongst the oldest old and those most likely to need care; a decline in fertility rates so that there are fewer children to care for more adult parents; high divorce and remarriage rates with the result that children have a greater number of parents to care for; women’s participation in the labour force; and changes in the financing of health care so that patients are discharged from hospitals earlier and more complex home care regimens are required.  

The preference for individual freedom and for limiting government involvement in economic and family life is key to American culture and ideology. This is manifest in the expectation that Americans will rely upon self-initiative to care for themselves and their families. To an extent Americans are expected to receive long-term care services from family members, or pay privately for most of their care services. Families are expected to finance time off (despite the inability of most families to do so), and legislative guarantees deal with reinstatement, not paid leave of absences. The development of comprehensive state programs would necessarily result in increased dependence on the state and income tax hikes, which would be viewed as a decrease in personal freedom.  

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230 Martin-Matthews, supra note 146 at 21. This article indicates that more conservative estimates put the number at 140.

231 For further discussion, see Martin-Matthews, supra note 146 at 23.

232 For further discussion, see Martin-Matthews, supra note 146 at 22-23.


234 Ibid, at 131.
Given the ideological disposition of the United States, a response to the demand for caregiving is more likely to come from employers, particularly medium and large-sized companies, rather than from government. The competition to recruit and retain workers may result in family-friendly benefits, including greater flexibility in work schedules, place of work, employee assistance programs, and other low-cost options. Leaves from employment are likely to remain unpaid. The difficulty the government experienced in passing the current legislation with respect to unpaid leaves suggests that it will be unlikely to tackle paid leaves. Without a legislative mandate, employers are also unlikely to offer paid leaves.\textsuperscript{235}

The provision of services by private agencies offering resource and referral, case management and convenience services is likely to increase, along with new types of supportive housing for elders involving housekeeping, medication management, home care and meal services. However, private services will naturally only be available to those who can afford to pay.\textsuperscript{236} Consequently, they will probably be inaccessible to lower income families and individuals, thereby resulting in greater disparities in the range of care solutions available to those with high and low incomes.

As a result, while certain trends in the U.S. will require increased support for employees with care responsibilities, these trends will be counterbalanced by political and ideological dispositions. There will be new opportunities for the wealthy and a few additional low-cost employer initiatives, but otherwise the future of the United States is likely to result in the same mix of public and private policies, benefits and services.\textsuperscript{237}

This paper has broadly considered aspects of the family and long-term care legislation of three jurisdictions in regard to responsibilities for caregiving throughout the life span. Traditionally, caring has been a task of women, in their capacities as wives, mothers, daughters and other relations. Women are increasingly entering the workforce, and a significant percentage of the workforce in all three jurisdictions is now comprised of women. Yet women continue to be the primary caregivers. The changes in the labour force raise questions about the possibility and the desirability of maintaining the traditional caregiving model.

Thus, it is interesting to consider the division of responsibilities between the state, family and individual as reflected in the legislation and systems of the countries. As this paper has shown, while all three selected nations are democratic, developed nations with strong social and economic institutions, their legislative approaches have not been uniform. In Sweden, consistent with a social welfare ideology, the state places the major responsibility for caregiving on itself, with strong support mechanisms offered to the family and individual. By contrast, Canada and, to an even greater extent, the U.S. focus more on individual-oriented solutions in which the state plays a smaller role. Given the different political and social ideologies, the system of one country may not be suitable for another, but instead may serve as a useful guide when considering how to address the evolving care needs of the population.

\textsuperscript{235} Ibid, at 136.
\textsuperscript{236} Ibid.
\textsuperscript{237} Ibid at 137.
LIST OF ABBREVIATIONS

(CAS) Children’s Aid Societies
(CFSA) Child and Family Services Act
(CHA) Canada Health Act
(CPC) Code on Parents and Children
(CYP) Care of Young Persons (Special Provision) Act
(FLA) Family Law Act
(HCCA) Health Care Consent Act
(HMSA) Health and Medical Services Act
(LTCA) Long Term Care Act
(MC) Code on Marriage
(NBHW) National Board of Health and Welfare
(SDA) Substitute Decision Act
(SSA) Social Security Act