Direct Financial Supports to Caregivers:
A Cost-Benefit Analysis

Prepared for the Ontario Caregiver Coalition by
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ABOUT THE ONTARIO CAREGIVER COALITION

The Ontario Caregiver Coalition (OCC) is the voice of caregivers in Ontario. We advocate for recognition and support for the family, friends, and neighbours whose unpaid care is the hidden backbone of Ontario's health care system. We are a not-for-profit organization, whose membership includes both unpaid caregivers and organizations that support them.

ABOUT THE AUTHORS

This research was undertaken as a volunteer project for the Ontario Caregiver Coalition, and supervised by its Research & Advocacy Committee. Work was carried out from February through June of 2022.

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INTRODUCTION

Among the many flaws that the COVID-19 pandemic exposed in Ontario's social and economic policy was the lack of recognition and support for the caregiving provided by family, friends and neighbours to Ontarians who are aging, living with disabilities or have acute health needs.

Caregivers provide vital practical, emotional, navigational and advocacy support for those they care for. Depending on the needs of their loved ones, they take on a variety of tasks. The most common activities are emotional support and transportation. Caregivers also handle financial needs, provide physical supports, schedule appointments and manage interactions with the health system, and provide basic medical supports.[1] Whether their loved ones share a home with them, live in the community, or live in a long-term care (LTC) or retirement home, caregivers safeguard, to the degree possible, their security, dignity and autonomy. As the pandemic demonstrated, they are the sustaining force behind health and long-term care systems that could not operate without them. For the most part, caregivers do this difficult and important work with minimal government supports, offering their time, their money, and their rest to support their loved ones. This can impact caregiver mental and physical health and economic security. The additional pressures, isolation and lack of supports during the pandemic have pushed many caregivers near their breaking point.

Ontarians have been clear that they prefer to live in community, rather than in institutional settings such as long-term care homes. The tragedies of the pandemic have reinforced that desire. However, care in the community relies on the creation of a strong network of support from families, friends and neighbours. For that network to be sustainable, caregivers require additional supports. As all political parties recognized in the 2022 provincial election, those supports include reliable, quality, adequate home and community care, as well as mental health, skills training and navigational supports for caregivers. One piece of the support puzzle that has until recently gone unrecognized is financial supports.

Caregiving is a costly venture. Caregivers across Ontario often must reduce time at work to maintain care. This is not only true of caregivers themselves – 45% also had family members modify their work or life arrangements to support care.[2] This represents a forfeiture of both immediate labour income and long-term professional opportunities. It also reduces opportunities for caregivers to save while often requiring them to draw down their existing savings to maintain care. In the long run, this can impact their ability to retire. Financial distress has a clear and direct effect on both mental and physical health, impacting the well-being of both caregivers and those they support. This is particularly true for more marginalized caregivers who lack financial resources and supports.[3] Without supports, caregivers confronting high out-of-pocket expenses may ultimately have no choice but to turn to institutional care to support their loved ones even when it may not be the best fit for their needs. Caregiver financial distress is a fundamental challenge for Ontario's health system.

There is a clear and pressing need for government to intervene. By supporting family caregivers through a cash benefit, government can empower them to better meet both their own needs and those of the people they support. This has not only health and social benefits, but also a direct financial benefit for government, because when caregivers are empowered, it reduces pressures on expensive institutional care. Supporting caregivers is not only a moral imperative, but a practical financial positive for government as well. There is growing recognition of this reality. In the last election, the Liberal, New Democratic, and Green parties all presented plans for a caregiver benefit of some kind, while the Progressive Conservatives recognized the need for financial relief and more supports.[4] While different approaches have been suggested, there is nonetheless a common recognition of a need for government to intervene.

However, there is a dearth of policy literature on the financial implications for government of direct financial supports for caregivers. A cost-benefit analysis is a useful tool for clarifying the policy debate and providing guidance for program design. This paper, using existing Canadian caregiver benefits as exemplars, estimates the cost, direct financial benefit, and impact for government to directly support caregivers. It demonstrates that a caregiver benefit in Ontario would be fiscally prudent and advantageous for government while addressing pressing needs in the health sector.

PROJECT BACKGROUND

Caregiver Financial Distress

For those needing supports to lead quality lives, family caregiving is at the centre of their support system. Backed by medical professionals, private care services, and public home and community care systems, family caregivers work to meet the medical, physical, and social needs of loved ones. Family caregiving also supports those receiving hospital care and congregate care (such as in retirement or long-term care homes) – in every setting, family caregivers continue to vital support and services. Family caregivers are committed to providing a quality of life for their loved ones that public supports alone could never ensure. While some care needs are related to acute conditions, many caregivers support loved ones with long-term needs – developmental disabilities, dementia, chronic illness, disability, or general aging – and who therefore require ongoing assistance.

Family caregiving is extremely widespread in Ontario – almost everyone will be a caregiver at some point in their lives. It is also costly to those who choose to do it.

- **Demographics:** 25% of Canadians aged 18 and over engage in at least one hour per week of family caregiving.[5] Half of this population provided up to five hours of care per week, 30% up to 19 hours, and 20% over 20 hours.
- **Spending:** Caregivers often find themselves with extensive out of pocket expenses, whether costs for transportation and parking, medical supplies and equipment, or private home care services.[6]
- **Impact on Work:** Time and energy spent caregiving – even before expenses involved – implies a forfeiture of time working for pay. This has both direct and indirect financial costs, chief among them being foregone income and professional opportunities.
- **Financial Impact:** Caregivers therefore face both reduced income and increased expenses. Meeting these obligations, most caregivers – although more women than men – received social support from family and friends, while equal numbers of women and men (22% and 23% respectively) received financial support, the largest source being family.7
- **Support Sources:** These family and voluntary supports are often insufficient. Among middle aged Ontario caregivers, 50% had to rely on personal finances for caregiving, 45% cut spending, and 40% dipped into savings. 40% of those supporting children with significant needs had to take loans, and a quarter have had to sell assets in order to cover the costs of care.

Thus, while care is essential to the basic functioning of the health system, it comes with major financial penalties to caregivers. When polled, 68% of family caregivers across Canada identified additional government financial support as their key need.[8] Similarly, a 2019 Ontario survey found 73% of family caregivers listing more government support as their key issue. Women between the ages of 35 and 64, and those supporting children, reported the highest levels of need for government financial support. The high cost of care to caregivers reduces both their capacity to sustain care and the level of care they can provide. The social value of care is extremely high, but its high financial and personal costs are major barriers to individuals delivering it. This represents a clear market failure.

In the long run, this lack of supports can make care in the community unsustainable for many caregivers, potentially leading both to extensive institutionalization, where more people end up in government-subsidized long-term care homes or other institutions than should be there, intensive institutionalization, where people end up in institutions earlier than they otherwise might. In both cases, caregiver financial distress may eventually leave dedicated and committed caregivers in a position where they cannot continue to support loved ones at home and institutional care becomes the reluctant, default choice.

PROJECT OBJECTIVES

Existing Research

The political environment is increasingly open to supports for caregivers. This is both a reaction to and a recognition of the need expressed by caregivers for more government support. The translation of need into policy, however, cannot be done without a stronger understanding of what a program to address caregiver financial distress would look like.

This is an understudied area. There have been a range of studies on the demographics and dynamics of care, from Statistics Canada as well as civil society. Civil society and activist groups have also carried out qualitative studies, focussed on the experience of care and the need caregivers face for more supports.

There has not, however, been a quantitative study on the impacts of supports either federally or provincially. The research gap is particularly acute regarding financial supports, as this is an under examined policy area more generally. For government to move from recognizing need to implementing policy, it needs a solid grasp on the scope of the commitment it is making and the potential benefits it garners. Decision-makers need better tools for understanding the challenge of caregiver financial distress, what the options are for addressing it, and how those measure up. We need clearer data not only on the scope of caregiver financial distress, but also which of the policy options available are the most efficient and effective. This project's purpose is to expand the scope of that data, thereby clarifying the fiscal case for direct financial supports to caregivers. The best format for accomplishing this is a cost benefit analysis.

Cost-Benefit Analyses

A cost-benefit analysis, in the context of this project, is a tool for government to consider different courses of action it can take when providing a social good. It assigns a dollar value to the price paid by the taxpayer for a course of action and the return on government's investment. It measures these inputs and outputs in dollar values, with money seen as a fairly neutral medium of exchange. The cost-benefit has become increasingly prominent as a policy tool in recent years, with the British government's Green Book offering guidelines on cost-benefits being a key marker.[9] The cost-benefit analysis is a vital tool for giving government context for action.

For this paper, Joseph Heath's concept of the "embedded" cost-benefit will be used.[10] Heath argues that a cost-benefit is not a useful tool for deciding which objectives are worthwhile for government to pursue, or which values government should consider. Cost-benefits do not exist to tell government what problems should be prioritized – that is a matter for civil society and democratic processes. Cost-benefits are "embedded" within these contexts and frameworks. Their goal is to evaluate alternative options for resolving a given problem or set of problems, establishing which of those options is the most financially efficient. It establishes what the cost of any given option might be, what its returns to government would be, and how these numbers compare to alternative options.

This is important because government time and resources are limited. Government has a duty to safeguard the public interest and the public's purse. It must choose, as much as practically possible, the most efficient way to meet public needs and provide social goods. For government to make policy, it needs to know how much those policy priorities would cost and how effective its spending would be. The more efficient a policy would be at meeting current challenges, the more likely government will be to adopt that policy. Cost-benefits are therefore an important potential tool for advocates looking to make a case to government.

POLICY ENVIRONMENT

Care and caregiving are attracting increasing policy and political interest. The current policy landscape for caregiver supports is complicated and interjurisdictional, with federal and provincial governments pursuing a range of approaches both cooperatively and separately. At present, there are four key models for supporting caregivers based on alternate understandings of their needs. The first, caregiver leave, assumes that caregiver financial distress comes from having to temporarily stop working. Expense supports locate financial distress in lump-sum medical and home-care costs incurred when adapting homes to meet the needs of those being supported. Direct financial supports see consistent expenses and reductions in medium- to long-term labour income as the key challenge. Finally, institutional models of care occupy the centre of current policy discourses but should be seen as a backstop for when care proves too complex and expensive to be continued at home. Governments across Canada have experimented with different versions and combinations of these policies to varying degrees of success. Overall, the direct financial support model has seen the most success at directly addressing financial distress.

Caregiver Leave

A widely adopted policy approach for caregiving is supporting temporary absences from the workforce. In Ontario, as in other provinces, the Employment Standards Act mandates employers to offer up to eight weeks of leave per family member per year.[11] These are not required to be paid leaves, but they do ensure that those taking leave retain a right to return to their jobs. Employers may choose to offer additional leave, or to cover the cost for some or all of this leave. The mandated minimum leave works in tandem with the federal Employment Insurance program. EI covers divergent, but fixed, amounts of time for caregiving leave. This can range from 15 weeks for an adult to 35 weeks for a child, while a separate policy offers 22 weeks for end of life care.[12] One can continue to work while receiving this EI, with benefits reduced by $0.50 per dollar of labour income.[13] This program has the advantage of subsidizing income during periods of reduced work and, due to being delivered through the EI system, avoids problems with tax filing and poverty.

However, these types of caregiving leaves present several problems.

- **Targeting:** The term of leave is short and clearly designed for illness or injury, rather than enduring issues.
- **EI Limits:** EI is based on prior income – a poor measure of need. This is especially true given that caregiving tends to reduce labour income.
- **Insufficient Spending:** Combining the Ontario leave with the most generous EI option – for a child – the total coverage is still 43 weeks, much of which is at the EI-capped maximum of 55% of labour income. Given the effects of caregiving on savings, 55% of normal income is insufficient.

- **Unemployment vs. Underemployment:** This model also assumes either full or near-full withdrawal from the labour market. Family caregivers may be forced to cut hours to part-time or reengineer shifts, but only 20% spend more than 19 hours a week on care. The vast majority need not subsidies for unemployment, but subsidies to help cope with underemployment.

Support on Expenses

A potential policy avenue to assist caregivers is assistance on specific care-related expenses. This assumes that most caregivers will be spending on certain things – for example, medical equipment – which are essential to the quality of life of those they support but also pose a serious financial burden. By subsidizing them, government can improve both the financial well-being of caregivers and the autonomy and health of those they support.

- **Federal:** The Canadian federal government has created a non-refundable tax credit covering a range of expenses related to personal medical need, home care, and assisted living. Most provinces and territories also have corresponding non-refundable tax credits. The federal credit offers either the lesser of either 3% of income or $2241 for either oneself or the person one is taking care of as a maximum for tax-deductible expenses.[14]
- **Ontario:** Ontario government has committed, in the 2022 election, to introducing a refundable tax credit for medical and home-care equipment and adaptation expenses covering seniors. The government will refund 25% of eligible spending up to $6000. This means, for example, that spending $5000 on eligible goods would result in a $1250 payment, while spending $8000 would result in a payment of 25% of the $6000 total eligible amount – a total payment of $1500.[15]

In theory, this approach has some merit as it could defray significant and common expenses. Practically, however, this approach has drawbacks.

- **Non-Refundability:** The existing federal and provincial tax credits are non-refundable and cover minimal amounts. Because of how the federal credit is structured, to maximize benefit from it one must be earning $74,700. Because the credit is non-refundable, there is also no benefit for those not earning enough to pay taxes. Government expenditure therefore does not correspond to need.
- **Initial Financial Resources:** The new provincial credit's formula of covering up to 25% of $6000 means that to take advantage of it, the eligible party must have $6000 to spend in the first place. Because it covers only a portion of expenditure at a flat rate, it also means that those with more money available to spend are more capable of taking advantage.

- **Retroactivity:** This form of support compensates eligible expenses. This has the implication that beneficiaries can front the money for the eligible expenses. Caregiving's proven reduction of savings means that many caregivers would be unable to spend in the front place. Even if low income caregivers actually made enough to be able to take advantage of the non-refundable credits, they would not be able to spend enough to take advantage. This form of credit is de facto regressive.
- **Inflexibility:** Unlike direct financial supports, spending-specific credits are prescriptive on what caregivers and those they support can use the money for. Beyond being paternalistic, this model also reduces flexibility. Not every caregiver will have significant medical equipment expenses. Caregiver supports should recognize the diversity of care and recognize the expertise and specific experiences of caregivers and those they support.
- **Specificity:** As previously noted, the key to caregiver financial distress is the reduction of labour income. Tackling expenses is certainly important for addressing financial distress. Easing lump sum initial expenses is essential for affirming autonomy and reducing barriers to care. It does not address, however, long-term labour income reductions in any strategy to support caregivers. These approaches are complementary, but expense supports must be paired with direct financial supports.

Direct Financial Supports to Caregivers

Various Canadian jurisdictions have developed a range of direct financial support programs. Unfortunately, there has not, as of yet, been any kind of comprehensive comparative evaluation of the impact and effectiveness of these approaches.

Non-refundable tax credits: One approach, cited in StatsCan as the most commonly-used program reaching 11% of caregivers,[16] is the Canada Caregiver Credit. This is a non-refundable tax credit, introduced as a consolidation of three prior credits in 2017,[17] which can reduce taxes paid but cannot be taken as a cash transfer if it outstrips one's tax bill.[18] This also makes it a de facto once-yearly payment, reducing flexibility. The tax system also has a range of existing exemptions to minimize the tax burden for the working poor – constituting large numbers of family caregivers – limiting the program's utility. However, the amounts offered – up to $7726 – are generous. Unlike other credits, this also covers caregivers supporting people under 18 years of age. Unfortunately, this credit only covers people with major health challenges – caring for those who elderly but otherwise comparatively healthy is not covered.[19] Another challenge is the hesitancy of lower earning income individuals and families to file taxes. While some refundable tax credits can be issued without filing,

non-refundable tax credits are applied to an existing bill and therefore offer no help without filing[20]. As well, non-refundable tax credits, by only subsidizing those with a high enough income to pay taxes after benefits for the low income, work best for those in income brackets who need it the least.

Caregiver Allowances: The oldest and best-studied financial caregiver support is Nova Scotia's Caregiver Benefit, which was piloted in 2009 by a Progressive Conservative government and rolled out province wide by their New Democratic successors. Policy rationales included an aging and urbanizing population, an overburdened hospital system, and a need for alternate arrangements.[21] The program offers a means-tested income supplement subsidizing low-income caregivers. Delivery is not through the tax system, avoiding the issues faced by the Canada Caregiver Credit but creating new bureaucracy.[22]

According to traditional economic theory, this program's status as a cash transfer is optimal as it maximizes agency for the target population.[23] Every caregiving situation is different, and every caregiver's and care recipient's needs are different. Therefore, a cash payment offers the caregiver maximum flexibility and minimum bureaucratic overheads in meeting their challenges. This is therefore, according to the theory, better than other interventions – for example, the EI provision of time or interventions around respite care – by affording maximum choice. Beyond that, the program seems to have met its objectives – early but regrettably unpublished studies suggested that it reduced institutionalization by up to 56%.[24] Praise was also offered for not requiring the caregiver to live with the care recipient, increasing the autonomy of both parties. However, criticisms included its means-tested income ceiling being too low, the insufficiency of the benefit to cover caregiver needs, and the exclusion of parent caregivers.[25]

Refundable Tax Credits: Manitoba, more recently, instituted a $1400/year Primary Caregiver Tax Credit. The Manitoba credit is notable for not mandating any specific family relationships between caregivers and those they support.[26] The credit is refundable, meaning that if the credit is larger than taxes owed, the credit is paid out in cash. This is better than the non-refundable federal credit, as it offers maximum advantage to those who have low incomes and therefore have comparatively lower tax bills, or who are already taking advantage of other refundable tax credits like the Canada Works Benefit. However, refundable tax credits face a problem in the lower likelihood of those living in low-income to file for taxes, which by some estimates represents a $1.7bn forfeit in 2015 alone.[27] With this in mind, does a reluctance to file limit the tax credit's reach, even as the welfare state is increasingly administered through the tax system? Some of this gap might be plugged by the provision of tax filing supports by social-justice organizations,[28] but the challenge remains.

Comprehensive caregiving framework: The most recent policy action on caregivers has been Quebec's Politique Nationale Pour les Personnes Proches Aidantes, signed into law in 2020. This is a comprehensive caregiving framework mandating government consultations with caregivers and advocacy organizations, the establishment of a standing committee, the five-year creation and renewal of a caregiving policy, and a set of principles and rights of caregivers to be included in any government action.[29] Along with these supports come several refundable tax credits covering caregivers supporting people 18 or older[30] and people over seventy without major health challenges[31]. This is further supplemented by a refundable tax credit allowing caregivers to freely disburse up to $1500 to any volunteers who provided respite.[32] Without evaluating credit generosity, the inclusion of aging healthy adults, along with the respite tax credit, are both welcome additions. However, the lack of coverage for parent caregivers of children under 18 with high needs is a missed opportunity.

The Fallback Option – Institutional Care

Where supports in the community are inadequate to meet needs, whether because of the intensity of needs or the lack of supports, individuals are more likely to be diverted into institutional settings, most commonly long-term care homes. Diverting people with chronic and intensive support needs into institutional care has consistently been the default option reinforced through path dependency. It is, nevertheless, flawed. In Ontario, regulations cap costs for long-term care homes at $2700/month for private spaces. Provincial subsidies are heavily means-tested and cover only $1800/month.[33] LTC facilities also consume $5.8bn/year of the Ontario budget, or around $70,000/resident.[34] Nationwide, the Parliamentary Budget Officer (PBO) suggests that an additional $13bn will be necessary in coming years to accommodate aging populations and post-COVID reform.[35] Ontario's LTC commission, in its final report, emphasized that the system was dangerously dysfunctional due to years of neglect, and even discounting pandemic preparedness measures was never equipped to meet resident needs.[36] The cost to families, to provinces, and to those needing support is therefore unacceptably high.

Summary

Combining earlier statistics with an institutional scan, the insufficiency of current measures becomes clear. While two-thirds of caregivers reported a need for more supports per StatsCan data, only 14% were receiving federal benefits. This demonstrates the limits of the non-refundable tax credit as a policy intervention. While Nova Scotia's program is the oldest, best-studied, and most demonstrably successful, Quebec's program demonstrates that new policy movement on family care is both urgent and possible.

Neither long-term care nor further leave policies sufficiently address the needs of caregivers who must continue to work, but sacrifice income and increase spending to support their loved ones. With these points in mind, any policy action must:

- relieve financial distress for existing caregivers, allowing them to sustain care and by so doing so, make family caregiving financially sustainable, allowing Ontarians to substitute caregiving for institutionalization over a longer time-frame.

There are care levels beyond which institutional care is the only option, but until those points are reached, care in the community should be made as viable as possible. Both economic theory and the practical demands of caregivers suggest that a cash transfer would be the best policy option.

METHODOLOGY

Theory and Approach

The basic method for a cost-benefit analysis includes four elements:

1. Identify a potential intervention.
2. Identify the costs of that intervention and the costs of not acting.
3. Compare the costs of either approach to identify potential savings.

Step 1: Identifying the Intervention

The working hypothesis for this analysis was that **direct financial support to caregivers would be less expensive to government than subsidies to institutions.** Caregivers, with government support, would be better able to meet the needs of their loved ones, adjust their time at work to meet their own needs and those of their loved ones better, and ultimately would be able to optimize the time and money spent on care. This is the model espoused in Nova Scotia, Quebec, and Manitoba. To test if this worked, two variables were needed – an intervention and an indicator, or alternately an independent and dependent variable.

The **chosen intervention** is a direct financial support to caregivers. The intervention was modelled using Nova Scotia's caregiver allowance, which recommended itself for several reasons.

- **It is a well-established program.** The last complete census was in 2012. The Nova Scotia benefit, being the chosen model, was implemented in 2006. All other caregiver supports were implemented recently enough that the census would not capture their effects. For example, while Quebec's program is potentially very interesting, it was implemented in 2021, so that it did not line up with the available census data, as well as being too new to see any appreciable effect on institutional care models – particularly considering its introduction during a pandemic. The Nova Scotia benefit, however, was well-established enough by the time of the census to have an appreciable effect.
- **Its relative generosity enable easier measurement of effect.** The Nova Scotia benefit is more generous than the Manitoba refundable tax credit. At $4800, the Nova Scotia program represented a support more likely to have significant effects, which also meant that it could be more accurately measured. This was the most generous support available in the Canadian context with data of the right age and comprehensiveness.

- **Its Canadian context allowed for easier cross-jurisdictional comparisons with Ontario.** While there are a range of interesting support models internationally, the location of the Nova Scotia program within the Canadian institutional context enables comparisons between jurisdictions and estimations of effect in Ontario more accurate.

The **chosen indicator** is spending on institutional care by government, and in particular, per-bed subsidies to long-term care homes. In Ontario, every long-term care bed – private or public – directly costs the government $68,000. This includes both the subsidy itself and supplementary spending for food, leisure, healthcare, and support staff. It does not include spending on physical infrastructure. Nor does it cover any supplemental spending or the various conditional supports which government may provide. It represents a baseline which is constant across all long-term care beds in Ontario. This provides a fairly clear and direct measure, as government is providing care in an institution as an alternative to care at home. While there are strong arguments that institutional care is both qualitatively and quantitatively insufficient to meet existing needs, it nonetheless represents in economic terms a substitute to family care. This means that subsidizing caregivers should have a direct impact on the need for long-term care spaces. The relationship is direct and concerned specifically with the dynamic this experiment is most interested in. While there are other potential impacts – on the health of the elderly and therefore usage of the health system, for instance – these have a less clear causal link. This offers a precise look at the impact of supports for care.

Step 2: Identifying Costs

The starting point was to find Statistics Canada's fast and slow aging scenarios as established in the last census. These projections are respectively the "worst" and "best" case scenarios, which were used as the upper and lower boundaries to project the likely maximum and minimum expenses related to this program. They establish the demographic baselines for the cost-benefit. Following this, Ontario's and Nova Scotia's rate of familial care in three age brackets – 65-74, 75-84, and 85+ - were used as the lower and upper boundaries of the care rate. For care, the StatsCan definition was used – to qualify, a person self-reports as having received assistance from family, friends or neighbours for a health problem or limitation in the past 12 months. These numbers were also taken from the census. With two demographic projections, this cost-benefit could cover a broad range of possibilities.

This study assumes that Ontario's care rates will be maintained at current levels. The core argument for this rests on how care is described in StatsCan's definition. This understanding of care is broad enough to cover the full range of caregiver activities, from occasional to full-time activities. It assumes that almost anyone who would be providing care already is. It also assumes that family caregiving could continue even after those being supported find themselves needing institutional support. However, the amount of care that caregivers can

provide is limited by financial pressures and the need to work. A benefit would allow people to adjust the amount of care they can provide, either by giving them financial space to reduce time at work, financially underwriting care expenses, or whatever combination best fits their needs and those of the person they are supporting. A benefit would not create large numbers of new caregivers – its primary effect would be to empower existing caregivers to better support their loved ones. The rate of self-reported care in Ontario would therefore remain at current levels.

Each of the demographic scenarios was then treated the same way. Once these rates were determined, the projected number of individuals in the mentioned age brackets multiplied by their respective care receipt rates, then summed to create a rough estimate of recipients of familial care. This was used to determine the number of recipients of the benefit. This, in turn, could be multiplied by $4800 – being the generosity of the Nova Scotia benefit, and therefore the hypothetical benefit for this study – to arrive at the final cost of a caregiver support. On the assumption that increased care – either more extensive or more intensive – would reduce the need for institutional care as represented by LTC beds, savings could then be estimated. This is difficult not only because data is sparse, but also because of the impossibility of determining future costs of LTC enrollment. As the population ages and enters LTC homes the increased demand on limited resources such as medical professional labour may raise the cost of LTC enrollment, while the diversion of resources towards supporting LTC may decrease aggregate supply relative to demand and drive inflation. One could speculate endlessly on the possible impacts of a ballooning LTC population, but it would not be possible to project future prices of LTC to taxpayers.

Step 3: Identifying Savings

The number used to determine savings was the value of the per-bed subsidy paid by the Ontario government to long-term care facilities. This was established by finding the current number of Nova Scotian and Ontarian long-term care beds, comparing the proportions of the Nova Scotian and Ontarian populations over the age of 65, and adjusting the Ontario bed numbers to the bed-to-population ratio in Nova Scotia. This is a deeply imperfect measurement complicated by economic, institutional, and demographic factors. It nonetheless establishes a rough equivalency and allowed for an estimation of how large Ontario's LTC system would be if Ontario were more like Nova Scotia, with the credit – after the demographic smoothing – being the key difference. This hypothetical difference in bed numbers could be multiplied by $68,000 – the per-bed subsidy – to establish savings. This could be projected forward on the assumption that LTC spaces would remain proportionate to elderly populations. To be clear, this measure demonstrates the value in LTC bed subsidies that could be replaced by a caregiver benefit. This could represent a reduction in the size of the sector, or more spaces available for individuals currently on the waitlist. It demonstrates the creation of direct financial value for government which could be realized in several

different ways. This also makes no assumptions about the mechanism for how the support accomplishes a reduction in LTC usage.

At this point, the cost-benefit could be completed. The costs for a caregiver benefit projected into the future and the savings from a potentially reduced LTC need provide – respectively – the cost and benefit. Subtracting the former from the latter establishes net savings. This also allows for the establishment of a ratio – that a dollar of spending on a caregiver benefit would have the same impact as a given amount on long-term care. While these measures could be enhanced with more case studies, no such data existed within the Canadian context.

RESERVATIONS AND LIMITATIONS

A number of reservations are attached to this analysis.

Age Range Limitations: The Nova Scotia benefit is payable only to those over the age of 65. Therefore, using this program as the referent excludes is a wide range of care activities and by extension additional costs and benefits which might be associated with a more inclusive model.

Median Income Differentials: The Nova Scotia credit cuts off at earnings of $40,000, which is around the median Nova Scotian income. For the purposes of this analysis, we also assumed an Ontario program which cuts off at the provincial median income. Because of how StatsCan data is divided,the eligibility limit closest to the median Ontario income when rounding up was $60000. This encompasses the large majority of Ontario citizens. There ongoing policy debate about the preferability of universal versus means tested programs is beyond the scope of this study: the choice to use a means tested approach was purely methodological. However, it means that we cannot establish whether a more generous benefit would have stronger effects.

Eligibility Criteria: The eligibility regime for the Nova Scotia credit is built on the assumption that each person receiving care would be matched with one primary caregiver who would be receiving the benefit. Nova Scotia also restricted eligibility through a limited definition of care. This created some methodological challenges, as this limited definition could not be reproduced for the Ontario data, which necessarily employed the much broader definition of care used by StatsCan. This includes persons who “received assistance from family, friends or neighbours for a health problem or limitation in the past 12 months”. Using this very generous definition of care creates what is likely an over expansive assumption regarding the reach of a Nova Scotia-style allowance in Ontario. Paired with the assumption that every person eligible for the benefit would apply for and receive it, this means that this analysis likely overestimates the cost of a caregiver benefit.

Inability to Track Change over Time: Statistics Canada restricts access to data attached to individual social security numbers. Lack of access to such data means that this study can comment on aggregate numbers, but cannot track change over time. Thus, while we can show a correlation between the existence of a credit and less demand for long-term care spaces, we cannot, however, show that any given person or group of people made the decision to continue care at home because of the credit. Although we can establish hypotheses about this relationship, we cannot say how exactly it works.

This limitation, along with the lack of access to data running further back in time, meant that changes in the dynamics and scope of caregiving could also not be tracked. An alternate hypothesis for how the Nova Scotia credit worked – that it boosted the number of individuals involved in caregiving – could therefore not be tested. The assumption is that with a cash

benefit, more people would be able to provide care. If the credit did in fact boost the number of caregivers, it might increase the costs of the program. It was unfortunately not possible to test this alternate hypothesis for this study. In part this is a result of the expansive StatsCan definition of care described above. Because of its breadth, it would be hard to detect rates of more intensive caregiving. The higher Nova Scotia rates are also impossible to correlate directly with the policy. There are a wide range of social, economic, and cultural factors which may also be responsible. This is further compounded by the dataset used being from after the Nova Scotia benefit was implemented, making a difference-in-differences analysis impossible. It was therefore not viable to investigate how exactly Nova Scotia's caregiver benefit worked, and what effect that might have on program costs.

Limitations of the LTC Indicator: The LTC usage measure also has limitations, as it does not capture most care recipients under the age of 65. Nor does it capture other potential avenues for savings in public health usage, for instance, or in institutional supports other than long-term care. It matches the chosen model for the support, but necessarily excludes large quantities of the population. As with the choice of the model, this should not be taken as an argument for a financial support excluding these segments of the population, nor an endorsement of any particular model of long-term care. It was intended only to demonstrate a direct relationship between the financial support and institutional care. It also assumes that long-term care and the dynamics around it are roughly similar in Ontario and Nova Scotia, and that one long-term care home is much like another. While demographic differences can be smoothed out in the data, there is still a degree of uncertainty inherent to comparing jurisdictions.

This study also assumes no major shifts in how long-term care works, including its cost to government, its availability, and the broader delivery model. Funding for home-care or community care and other caregiver supports is also assumed not to change. While more programs would be desirable, they cannot be accounted for in this study.

Finally, the precision of this measure lessens the broader financial impact of this decision. It cannot capture, for instance, spending on infrastructure instead of LTC residents. Nor can it track the positive effects this program might have on poverty or the broader dynamics of care.

Reliance on Demographic Projections: Because this study – and the estimates about both costs for the support and long-term care savings – are based on current StatsCan demographic projections, it must also be assumed that these are correct. While both the slower-aging and the faster-aging cases were used to capture the range of likely scenarios, this does exclude unexpected demographic shocks could change these dynamics or that StatsCan's projections could be wrong. It must therefore be assumed that these projections are correct and will hold. This has implications both for the growth of the long term care sector and for the populations needing care.

RESULTS

This study demonstrated that, if certain assumptions about long-term care hold, a **direct financial support for caregivers based on existing Canadian models would represent a net saving for the government of Ontario which would increase over time.** This holds true for both the more and less optimistic Statistics Canada projections for aging. In all cases, a caregiver benefit could replace 7.8% of Ontario's long-term care beds.

In StatsCan's slow aging scenario, this represents net yearly savings to government of **$307mn per year** in 2022, escalating to **$390mn per year** in 2040. In this scenario, the numbers indicate that $1 in spending on caregiver supports is equivalent in impact to **$1.69 on institutional long term care**. This is a clear demonstration of the fiscal efficiency of direct benefits. (Fig. 1)

In the fast aging scenario, savings start at **$307mn per year** and escalate to **$343mn per year** by 2040. Gross savings per year, however, are significantly higher at **$745mn**. This reflects both the higher costs and benefits of the policy in a scenario where the population ages faster. (Fig. 2)

Practically, this study cannot estimate what immediate savings would look like upon hypothetical policy rollout or how implementation would change these numbers – that would be out of scope. It instead is intended to show, clearly and directly, that the government would see a strong net budget benefit from implementing direct financial supports for caregivers.

Current events and civil society have brought new attention to the care system and clarified the need for additional investments. The question now is how best to spend those resources to ensure both caregivers and those receiving care are treated with dignity. This cost-benefit shows that in pure dollar values, proven measures to alleviate caregiver financial distress are a reliable way to strengthen the care sector and improve system outcomes. Supports to caregivers are not only an effective option, but financially efficient. Alleviating financial distress is a prudent use of taxpayer funds which, beyond affirming the value of care and improving health outcomes, is a net financial benefit to government and the most efficient way to spend resources. Cost-benefits exist to demonstrate the most financially responsible option for government to address a given issue – and in this case, that option is clearly a direct benefit to alleviate financial distress.

NEXT STEPS

Although the project here has clear and compelling explanatory power, it could be enhanced with a broader look at other indicators and access to more data. With more resources and more access to information, there are several approaches which could improve the understanding of both the benefits and the functioning of direct financial supports for caregivers.

- One approach would be to take a broader social-determinants lens, then use this to establish **differences in health system costs**. This could be done, for example, by evaluating hospital check-ins for individuals within the age range covered by the Nova Scotia credit in Nova Scotia and New Brunswick. This would be a useful point of reference, as it might better test the social determinants of health model and, by extension, the costs of poorer and therefore less healthy elderly citizens.
- Another potential angle would be to identify **institutional care systems for those under the age of 65**. A caregiver benefit would, ideally, be universal and not locked into an age range like the Nova Scotia model. It would support and validate care for a wider range of demographics. Further study could identify institutional expenditures as indicators for the success of such a project, along with comparable support programs – for example, Ontario's Passport – as independent variables.
- Any study could be enhanced with access to **StatsCan data attached to individual social security numbers**. This could track changes in status – for instance, moving into institutional care. The LTC usage metric can only follow aggregate trends – individual social security numbers could determine not only whether a policy has an impact as this study currently does, but also how that impact works. This data is maintained behind high barriers of access by Statistics Canada. Better-established researchers with more time could potentially access it, increasing the scope of what could be accomplished.

CONCLUSIONS

While the need for supports to caregivers has been consistent across time, the steadily increasing pace of policy action across the past decade has showed that support to family caregivers is rapidly becoming a key issue, particularly post-pandemic. It is more vital than ever that caregivers receive the support from government they and their loved ones need.

There remains a wide range of research to address serious gaps in policy knowledge about direct financial support programs for caregivers. With more time, more resources, and better access to data, future researchers could enhance the work of this cost-benefit analysis.

However, as a first step, this cost benefit analysis points to a clear and compelling case for a fiscal case for direct financial supports for caregivers. Better supports for caregivers reduce the need for institutional care, saving government money. The sooner government acts, the more effectively it can both move away from institutional care and realize direct budget savings. That is, supporting caregivers meets not only the needs of caregivers, but also those of government. Reducing financial distress is a fiscally rational and budget-positive policy direction for supporting the well-being of caregivers, improving the health and dignity of those they support, moving Ontario's budget towards balance, and proactively building a better health system for all Ontarians.