Continuing Care in British Columbia: Public Policy and Need

by

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ABSTRACT

In recent years concerns over the sustainability of the current health care system has lead to a growing interest in home care services as a cheaper alternative to long-term institutional care. Despite the focus on in-home care as a cost-effective and preferable care arrangement, there has been comparatively little research conducted on how in-home care policies may impact upon older adults' access to needed care services.

This study is guided by a political economy approach to aging. It examines how eligibility criteria may impact on the ability of older adults experiencing health-related care needs to access in-home care service. Particular attention is given to class and gender. Findings indicate that although class status does not appear to be a significant predictor of the receipt of in-home care services, there is evidence that older women are less likely to receive in-home care services than are older men. The implications of these findings are discussed and directions for future research proposed.

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Chapter 1: Introduction

Canada's health care system has been described as "...a source of pride for Canadians and a cherished symbol of the values of equity and compassion that are intrinsic to our national identity" (National Advisory Council on Aging, 1995, p. 10). However, in recent years, in response to federal reductions in health care funding, as well as the perceived crisis of an aging population needing increasingly more care, provinces have expressed a need to change the health care system in order to reduce costs. Health care restructuring has resulted in hospital and bed closures across Canada, as well as shorter hospital stays and falling hospital admission rates (Wilkins and Park, 1998). Virtually every province has focused on in-home care as a less expensive alternative and preferable care arrangement to various forms of institutional care. Despite this shift in care philosophy, there has been comparatively little research conducted in Canada on the impact of home care policies in relation to accessibility. The focus of this research therefore, is to examine how eligibility criteria may impact upon the ability of older adults who experience health-related care needs to access home care services, using British Columbia as an example.

Although the mandate of the Continuing Care Act in British Columbia is to support adults who have needs arising from a long-term health condition (British Columbia Ministry of Health, 2000), critics have argued that in an effort to control costs, eligibility criteria have become increasingly restrictive (Vogel, 2000). Currently, eligibility for publicly subsidized home support services in British Columbia is based on age, health status, residency, income and citizenship. For nursing or rehabilitative services, the provision of care is determined by physical health status (British Columbia Ministry of Health, 2000). However, little research has been conducted on the implications of such restrictions. A review of the relevant literature suggests that limitations placed on accessibility to home care services may have an especially negative impact on the lives of older adults, women and those of lower class status, as they are the most likely to experience chronic health conditions and need assistance with everyday activities in order to remain independently in their homes (Wilkins and Park, 1996).

In order to address how eligibility criteria in British Columbia may impact upon the ability of older adults to access to in-home care services, a political economy approach which places age, gender and class as central concerns has been chosen to guide this study. The central objective of such an approach is to analyze the structural characteristics and interrelationships of the state and the economy in the distribution and allocation of the resources, which may maintain or create inequality in old age (McMullin, 2000; Quadagno and Reid, 1999). As a critical theory, a political economy approach directs our attention to class, gender and age-related inequalities, which are created in the market and maintained through the state, often through social welfare policies. In applying this approach to an examination of accessibility to home care services, we are compelled to examine how eligibility criteria may impact upon the ability of older adults, women and those of lower class status to access in-home care. Further, given that a political economy approach recognizes that the experiences of older adults will vary by social location, the intersections of class and gender are afforded special attention.

Guided by this approach, data collected as part of the Patterns of Care Project (Penning et al., 1996) carried out from 1995-1998 in the Capital Regional Health District of Victoria, British Columbia are used to examine how class and gender may impact upon the ability to access home care services. Bivariate and multivariate statistical techniques are employed to determine both the order effects and interactions between class and gender in relation the type and extent of care received, if at all, and portion of care privately paid for among older adults experiencing functional limitations.

This thesis begins by examining a traditional political economy approach that explores the interactions of the market and the state in creating and maintaining inequality along class lines. A feminist critique of this framework is offered, and an alternate model, which includes gender as a central concern, is discussed. An examination of how both traditional and feminist political economy perspectives have neglected age as a central concern is offered, and the fundamental arguments of a political economy approach on age are presented.

Following the discussion of political economy is a review of literature that outlines the development of health and home care policy in Canada, and examines British

Columbia's home care policy in the context of health reforms. The potential implications of these policies, as they relate to older adults and informal care providers are then discussed, with special attention given to class and gender. Following this, the organization and delivery of home care in British Columbia is outlined and research questions that examine eligibility criteria and need for care are presented.

The fourth chapter outlines the methods and procedures used for collecting and interpreting the data utilized in this study. Results of the analyses are presented in chapter five. Key findings are presented in chapter six, along with a discussion of the potential implications of the results, limitations of the study and directions for future research.

Chapter 2: Theoretical Framework – Political Economy of Age

This study is guided by a political economy perspective that incorporates age, gender and class as central concerns. Although the term 'political economy' sometimes refers to the interplay of public and private or the state and market, at other times it refers to what is being studied, or to a particular theoretical or methodological approach to analyzing society (Esping-Andersen, 1999; Quadagno and Reid, 1999). It is political economy as a theoretical approach that is the central concern of this discussion.

Political economy as a theoretical perspective has its roots in both Liberalism and Marxism, but has since expanded beyond the works of Mills or Marx (Armstrong, 2001). Harold Innis' (1970) famous examination of how the fur trade shaped Canadian political, social and economic life brought a political economy approach that was distinctly Canadian to the attention of scholars. Subsequent scholars such as Wallace Clement (1977, 1999, 2001) and Leo Pantich (1977, 1981) investigated the linked economic and political forces that helped structure social life in Canada giving special attention to labour processes and relations, as well as resistance to these forces. More recently, "feminists and post-modernists have pushed political economy approaches beyond an exclusive focus on classes, formal economies and ideologies to include households, differences within classes, social movements, discourses, subjectivities, and power relations that extend far beyond the formal workplace" (Armstrong, 2001, p. 1).

Indeed, there is no one approach to political economy. Although "...the overarching tradition in Canada is one that investigates the relationship between the economy and politics as they affect social and cultural life" (Clement, 1999, p. 5), there are different traditions within Canada emphasizing differing elements of the Canadian political economy or applying comparative analyses (with other nations). Clement (2001) notes that neo-conservative political economy; liberal political economy; social-democratic political economy; comparative political economy; socialist political economy and feminist political economy may all be counted as variants of political economy. It becomes clear that a simple definition of "the political economy approach" is difficult in such a dynamic field of inquiry whose boundaries and core concerns are constantly shifting in response to theoretical debates and societal changes.

While it is beyond the scope of this discussion to explore all of these variations, there is a common thread among all political economy perspectives. "Political economy in all its variety shares basic assumptions that not only distinguish this approach from others but justify this frequently conflict-laden theory" (Armstrong 2001, p.1). Specifically, in political economy approaches, the political includes not only governments and governance, but is concerned with all power relations. Similarly, the economic side of political economy recognizes that "the economy is both political and social, with the social embodying both cultural and ideological aspects..." (Clement, 1999, p. 5). This understanding of the interplay between the economy, politics (as expressed through the state or power relations in general) and society allows for a broad framework with which to examine a variety of phenomena.

2.1 The Economy

The nature of the economy is a central concern of a political economic theoretical approach, and essential in understanding how the workings of the state may create inequality in Canada. In Canada today, the dominant mode of production is a particular form of capitalism. In recent years there has been a fundamental shift in state-market relations with a growing emphasis on international trade and the proliferation of multinational corporations. However, before examining the current form of the Canadian capitalist economy, it is useful to outline some features of capitalist economies in general.

Capital within the Marxian framework refers to "... the social relationship between the buyers and sellers of labour-power. The capitalist system is the social structure that emerges on the basis of that relationship" (Ritzer, 1996, p. 172). As an independent structure, capital exploits workers through control of the means and the mode of production. The control that the ruling class has creates inequality based on social class.

Under capitalism, ownership and control of the means of production is in the hands of a very powerful group that comprises a small part of the population. The means of production refers to the mode and tools of production. Within a capitalist framework, mass production is essential. This has led to assembly lines, the division of labour, and

the separation of workers from that which they produce. Profitability is assured only through mass, efficient productivity that cannot be accomplished on a small scale by one individual. As a result, a few people own the means of production, while the rest sell their labour power for a wage in order to survive in a capitalist economy (Marx, 1993). "A dominant class appropriates and controls the means of production. It is supported by a class which labours to produce the subsistence of the ruling class as well as for itself" (Smith, 1985, p. 7). Because workers have no means of producing for themselves outside the control of the bourgeoisie (the ruling class) within a capitalist framework, they are dependent upon the ruling class to survive. This division between those who own the means of production and those who do not is the foundation for class divisions. "Social classes arise out of the acts of production" (Ritzer, 1996a, p. 175). Otherwise put, relationships between individuals are shaped by their relative positions in regards to the means of production; that is, by their differential access to scarce resources and power.

The process of production and reproduction that takes place through the market in labour and goods is not primarily organized around the goal of meeting human needs, but around the capitalist mandate to accumulate (Ferguson, 1999, p. 13). The process of capitalism commodifies anything that is seen as potentially profitable in order to expand its power. As greater numbers of people work outside of their homes for a wage, they become increasingly dependent upon the market to fulfill needs that were once provided for at home (Ferguson, 1999). This dependence on the market to meet their needs, increases their dependence upon wage labour, and gives capital more power as people's ability to sustain themselves and others depends on their ability to earn a wage (Ferguson, 1999).

In order to ensure the profitability of capital, there must be a surplus of labour. Capitalism is not a self-sustaining entity. Capital accumulation, the market's mandate, depends on the existence of both free and waged labour (Ferguson, 1999). Capital needs an 'industrial reserve army' in order to remain profitable, as wages are measured on scarcity and skill (Marx, 1993). Thus, the greater the levels of unemployment in a given society, the lower the value of wages, and the greater the profitability for those in power, making unemployment a necessary element of capitalism.

Although it may be argued that these fundamental features inherent to capitalism (the presence of class divisions, capital accumulation, unemployment, concentration of capital) have not changed since the industrial revolution (Clement and Myles, 1994), the nature of the economy itself and dominant modes of production have gone through a tremendous shift in many western-democratic states. At one time, the Canadian economy was described as industrial, often as Fordist in nature with assembly line, large-scale production and an emphasis on a 'staple' economy (natural resources). Today, however, the Canadian economy is frequently described as postindustrial or post-Fordist (Clement and Myles, 1994).

Clement and Myles (1993) note that in some respects, postindustrial economies resemble their industrial predecessors in that there remains a small ruling class consisting of corporate owners and executives, although class structures themselves have changed. Class analysis of post-industrial political economies requires the inclusion of the middle class. "The key class affected by the rise of corporate capitalism is the fully emerged new middle class, which lacks real economic ownership of the means of production but exercises control and surveillance over labour, therefore performing part of the "global function of capital" while also (but not necessarily) contributing to the function of the collective worker" (Clement and Myles, 1994, p. 12). Thus, although class formation may be understood as the relationship between workers and their relationship to the means of production, it may also be understood in relation to the labour power of others. Those of higher class status (capitalists, executives and the new middle class) command not only capital, but are also able to exert power over others. Thus, those in higher-class positions are afforded greater financial resources, power, control and prestige, although this power will vary among capitalists and the middle class. As Myles and Clement (1993: 239) state: "like industrial capitalism, postindustrial capitalism remains a form of rule of the many by the few".

2.2 The State

There has been a considerable amount of theorizing and discourse surrounding the role of the modern welfare state. Welfare states are one element of capitalist-economic

and political development. Whereas the nineteenth century night "watchman state" was largely focused on the protection of property and national boundaries, welfare states extended their role to provide some social welfare for their citizens. Thus, "the welfare state is generally defined to include both government expenditures on services such as education, health, social security and welfare, housing, community and other social services, and government cash-transfer expenditures on pensions, unemployment insurance, family allowances and so forth" (Bakker and Scott, 1999, p. 287). Although there is little consensus about why the welfare state emerged and what purpose it ultimately served, there are several paradigms that have been highly influential in the literature.

The liberalist/pluralist or industrialization perspective traces the expansion of state activity to efforts to sustain and support working peoples and 'dependent groups' such as children and the elderly, through the transition from agricultural to industrial economies (Bakker and Scott, 1999). From this perspective, "the process of industrialization creates new demands for public spending as systems of social support based on kinship, and the patrimonial traditions of agrarian societies are eroded" (Myles and Quadagno, 2002, p. 36). For the most part, this work shares a liberal-pluralist view of the state as a neutral mechanism that operates in response to societal demands.

A neo-Marxist approach to the welfare state challenges the assumption that the liberal state is indeed a neutral entity, and argues that the state exists not to protect people, but rather to secure the reproduction of capitalist relations. "Welfare state expansion, James O'Connor (1973) argued, was driven by the dual, if contradictory, imperatives imposed on the capitalist state to create conditions of capital accumulation on the one hand, and the social legitimization of the mode of production, on the other" (Myles and Quadagno, 2002). Although the industrialist and neo-Marxist perspectives differ in their understanding of what interests the welfare state serves (i.e., the protection of the populace or the protection of capital), both perspectives share a focus on economic forces that compel a common response (Myles and Quadagno, 2002).

The third major theoretical understanding of the emergence of the welfare state stems from power resource theory. While the industrialization thesis argues that changing forces of production are the primary forces behind welfare state expansion, and neo-

Marxist accounts emphasize changing relations of production, power resource theory emphasizes both the forces of capitalism and democracy (including power relations) in creating and shaping the welfare state (Myles and Quadagno, 2002). It is for this reason that it has been a popular framework in understanding the role of the state within a political economy approach. Power resource theory is based on a theory of distribution in capitalist democracies. "Gerhardt Lenski argued that democratic politics created possibilities for the "many" (the working class) to combine against the "few" (the elites) and use the state to claim a larger share of the social surplus. However, the institution of private property biases this struggle in favor of the propertied because electoral constituencies are large and elections costly" (Myles and Quadagno, 2002, p. 37). For those in the working class, the only compensating power is in their numbers. In order to exert this power, mass organizations in the form of unions and parties must be established, and the working class must use their votes to elect explicitly class-based parties to represent their interests for greater equality to be achieved (Myles and Quadagno, 2002). Thus, according to this model, social welfare provisions are the result of both political and economic forces.

The power resource model and the idea that both the political and the economic matter in shaping the welfare state were further built upon by Gosta Esping-Andersen (1989, 1990, 1999). Esping-Andersen (1989, 1990, 1999) incorporates both class and political relations and applies T.H. Marshall's (1965) concept of citizenship in order create a typology of welfare states on the basis of a convergence of characteristics.

According to Marshall (1965), citizenship includes civil, political, social and economic rights. "Each classification in his view, is a site of struggle between individual actors and the state over how the boundary of inclusion/exclusion of citizenship is determined" (Benoit, 2000, p. 18). Specifically, civil citizenship refers to an individual's legal rights, political citizenship refers to the individual's right to enter the democratic process, and social citizenship refers to the individual's rights to economic welfare, education and social security conferred by the state in order to minimize the negative effects of capitalism (Benoit, 2000). Marshall argued that the formation of the welfare state would make available to citizens a broad range of social rights leading to "a general enrichment of the concrete substance of civilized life, a general reduction of risk and

insecurity, an equalization between the more and less fortunate of all levels" (Benoit, 2000, p. 19). The key elements of citizenship then, go beyond a set of legal rules governing the relationship between individuals and state in which they live, to include a set of social relationships between individuals and the state and between individual citizens.

Placing T.H. Marshall's concept of social citizenship as a central component of his analysis, Gosta Esping-Anderson (1989, 1990, 1999) has argued that the key principles of social citizenship as outlined by Marshall must involve: the granting of social rights which protect the status of the individual in relation to the market; that the individual's status as a citizen compete with or even replace his or her class position; and an understanding of the welfare state in terms of interactions between the market, the family and the state. Thus, the state's commitment to social welfare cannot be evaluated only in terms of the amount of expenditures, but must also include an understanding of the state's role in the market and the comprehensiveness of social programs for all its citizens.

Following this line of argument, one of the fundamental aspects of the welfare state is its commitment to granting individuals social rights to participate in the community/nation as full citizens. One way this is accomplished is through the decommodification of labour. Within the capitalist-democratic system, workers are entirely dependent upon their ability to earn a wage for survival. The process of decommodification provides an alternative means of welfare to that of the market. "Welfare states de-commodify labour as they enact provisions, such as unemployment insurance, which allow workers some protection against the necessity of selling their labour at any price" (Evans and Werkele, 1997, p. 10). Thus, highly decommodified welfare states allow all of their citizens to opt out of work without fear of job loss or general welfare, when they themselves consider it necessary for reasons associated with health, family or age (Esping-Andersen, 1989).

Esping-Anderson argues that welfare states must be compared on the basis of the range and nature of state activity directed at meeting the interests of their citizens as well as the stratifying or destratifying effects of these activities. Although it has been argued that the role of the state is to protect and provide for all its citizens, Esping-Anderson

takes a more critical view of the modern welfare state. "The welfare state is not just a mechanism that intervenes in, and possibly corrects, the structure of inequality; it is, in its own right, a system of stratification. It orders actively and directly social relations" (Esping-Anderson, 1989, p. 22). He argues that through comparative and historical analyses, it is possible to identify several systems of stratification embedded in welfare states. He identifies three types of 'welfare regimes' based on the dimensions of de-commodification and destratification, and how well states meet the interests of their citizens, or conversely how well they meet the interests of capital.

The first type of welfare state regime is the social democratic which is the most de-commodified and least stratified of the welfare states. This type of welfare state regime is the least prevalent of all the welfare state regimes, composed mainly of Nordic countries such as Norway and Sweden, and to a lesser degree Denmark and Finland (Esping-Anderson, 1989, 1999). Within this type of welfare state regime, there are clear principles of universalism and decomodification, which extends to the middle class. Thus, unlike other regime-types that promote means-testing and provide only a minimum of social welfare, social democratic states pursue a welfare state that promotes greater equality. As noted by Esping Andersen (1989, p.26) "this implied, first that services and benefits be upgraded to levels commensurable to even the most discriminating tastes of the new middle classes; and, secondly, that equality be furnished by guaranteeing workers full participation in the quality of rights enjoyed by the better off". Thus, manual workers and white-collar employees or civil servants enjoy the same rights and are entitled to the same services and quality of life in relation to social welfare programs. Such models reduce the power of the market, and consequently, all benefit and are dependent upon the welfare state. This, Esping-Andersen argues (1989, 1990, 1999), produces a high level of support for and solidarity behind its continuation and maintenance.

The social democratic model addresses both the market and the traditional family. "The ideal in this model is not to maximize dependence on the family, but capacities for individual independence. In this sense, the model is a particular fusion of liberalism and socialism" (Esping-Andersen, 1989, p. 26). He further argues that this welfare type regime was possible only because the private welfare market was relatively undeveloped.

The second type is the conservative-corporatist regime and is characterized by nations such as France and Germany, which also have a high level of de-commodification, but are also characterized by a greater level of stratification that maintain rather than diminish class differences (Esping-Anderson, 1989). "In these corporatist welfare states, the liberal obsession with market efficiency and commodification was never pre-eminent and, as such, the granting of social rights was hardly ever a seriously contested issue. What predominated was the preservation of status differentials; rights therefore, were attached to class and status" (Esping-Anderson, 1989, p. 25). He further argues that the social insurance model that assigns benefits according to one's social class, affording greater rights and privileges to those with greater class status, maintains and recreates stratification. Thus, although the market had limited influence within these regime types, class statuses and limitations in terms of rights and entitlements were upheld, meaning that the state's redistributive effects were minimal.

The corporatist regimes were also said to be heavily influenced by the church, and were therefore influenced by the strong commitment to uphold and maintain traditional nuclear family patterns. Social insurance was traditionally limited to working-men. Family services such as day care or formal family care services were only subsidized when the family's capacity to serve other family members was exhausted.

The third type of welfare state regime is the liberal welfare state. Canada, along with the United States, Australia and Great Britain, have been identified as liberal welfare states (Coburn, 2002, 2003; Esping-Andersen, 1989, 1999; Navarro, 2002). This regime-type places greater emphasis on the market than on social welfare. Social welfare programs are generally means-tested forms of assistance, or modest social transfers which generally cater to those with low incomes, usually working class state dependents.

Esping-Anderson (1989) argues that the poor relief tradition and means-testing social assistance programs were specifically designed as components of a system of stratification by punishing and stigmatizing the recipients of such assistance who were/are mainly comprised of the working classes. Further, Esping-Andersen (1989) argues that that liberal welfare regimes have been heavily influenced by traditional, liberal work-ethic norms, circumscribing the progress of social reform. "Entitlement rules are therefore strict and often associated with stigma; benefits are typically modest. In

turn, the state encourages the market, either passively by guaranteeing only a minimum, or actively by subsidizing private welfare schemes" (Esping-Andersen, 1989, p. 25). The consequence of this is that this welfare state regime encourages commodification which contains the 'realm of social rights' and not only maintains but creates a stratification order that blends an 'equality of poverty' among those who are the recipients of state administered social welfare.

Liberal welfare states also tend to adopt a narrow view of what is considered social, targeting family welfare programs to those considered to be at high risk of having to remove themselves from the formal market due to familial responsibilities. Thus, subsidized childcare and family benefits are typically afforded only to those with very low incomes (Esping-Andersen, 1999).

Esping-Andersen posits that these nations developed this type of welfare state because the new middle class thrived within the market. The welfare state caters essentially to the working class and the poor, whereas private insurance is afforded to the middle class through employment. "Given the electoral importance of the latter, it is quite logical that further expansion of welfare state activities are resisted" (Esping-Andersen, 1989, p. 29). Thus, we can see that liberal-type welfare state regimes have particularly strong ties to the workings of the economy and that the market, as opposed to social welfare and entitlements, is afforded primacy. Thus, Esping-Anderson argues that welfare states vary considerably with respect to their principles of rights and stratification, which result in qualitative differences in the arrangements between the state, the market and the family.

2.3 Postindustrial Economies: Globalization and the Welfare State

Postindustrial economies diverge from industrial ones in several key ways. First, the nature of production in relation to manufacturing has changed within the industrial sector in postindustrial economies[1]. The proliferation of multinational corporations, technological innovation and international trade has profound implications both for the

[1] The industrial sector includes manufacturing, construction and natural resources and resource based production – such as mining (Clement and Myles, 1993)

economy and labour relations in Canada. Indeed, "global trade and capital mobility are often seen as the culprits of de-industrialization" (Esping-Andersen, 1999, p. 101).

Free trade is the central supporting apparatus of globalization. In order to achieve a single world market, international corporations consider essential the need to establish conditions so that they are free to produce and distribute goods and services without interference from governments (Cohen, 1997). The stated purpose of free trade agreements is to eliminate practices in countries that may constitute barriers to trade. However, as Cohen (1997, p. 32) notes: "the concept of free trade now involves institutions and rules which are designed to facilitate capital mobility as well".

The consequence of these developments is that multinational corporations claim no allegiance to any one nation and are able to move production facilities to nations with fewer labour laws, that are largely un-unionized and have lower minimum wages. While at one time, an unskilled labourer could earn a living wage; technological advances have meant that there is now a declining need for less-qualified workers in the production sector. "Golden age capitalism could absorb masses of low-skilled workers on simple assembly line production, churning out mass production goods for which there was massive demand. It is these jobs that are rapidly disappearing within the advanced economies and, as we know, virtually all net new job growth will have to come from services" (Esping-Andersen, 1999, p. 103).

Unlike industrial or Fordist economies and their emphasis on mass production of products, postindustrial economies emphasize the production of services. "The distinctive feature of the North American labour market is the large share of employment in personal, retail and business services" (Clement and Myles, 1993, p. 29)[2]. Unlike Nordic economies that see greater levels of employment in government subsidized health, education and social services which are associated with unionization and higher wages, North American economies are increasingly founded on service sectors that are characterized by poor wages and low-skilled, often temporary work. The consequence of

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[2] Personal services include those services that could be performed in the household such as serving food and drink, cutting hair, cleaning and similar activities. Business services include finance, insurance, real estate and business related professional services such as accounting. Retail services include the selling of goods. (Esping-Andersen, 1999)

this growth is said to be a declining middle class and a greater polarization between rich and poor (Coburn, 2002; Poland et al., 1998).

Thus, although Canada has a diverse economy and is still heavily dependent on traditional forms of production, particularly in the realm of natural resources, globalization has also led to fundamental shifts in the mode and means of production. Additionally, a global economy has led to Canada's increased dependence on export and international markets for its wealth (Clement and Myles, 1994).

According to Coburn (2003), a major criticism of economic globalization is that it vitiates democratic processes. Corporations are now geographically mobile and free of national controls. "Corporate power has been vastly increased; it is entrenched in international free trade treaties at the expense of the autonomy and power of states, workers and citizens" (Coburn, 2003, p. 28). Although corporate power has been increased, it does not mean that particular political policies or outcomes are inevitable. "National business classes lobby for global neoliberalism to enhance their own power nationally and internationally" (Coburn, 2003, p. 30), Thus, we can see the ties between the global market and the local political stage.

The significance of these events is in relation to their material and ideological effects within and on a nation. Materially, international economic, political and social forces play a role in shaping - both directly and indirectly - national economic, political and social policies. Ideologically, assertions surrounding the need to be competitive in the global market have been used to defend neo-liberal policies and to reinforce the necessity for corporate economic power (Coburn, 2003; Navarro, 2002). Coburn (2003, p. 28) argues that:

> The essence of neoliberalism, in its pure form, is an adherence to the virtues of a free market economy, and, by extension, market oriented society. The New Right is not particularly concerned about inequality. It regards income or wealth disparities either as a virtue (reflecting unequal contributions to the public welfare) or as inevitable or necessary.

The welfare state, to the extent that its functions include the amelioration of inequalities of the marketplace, interferes with this neo-liberal view of the normal functioning of economies.

Based on this view, some argue that the forces of globalization are leading to a dismantling of the welfare state in Canada (Coburn, 2002, 2003; Navarro, 2002; Poland et al., 1998). This shift in political ideology in reference to the role of the state in the market has been considered to have a profound influence on the relations and conditions of work. The liberal welfare state is confronted with a contradiction in taking on the role of both protector of citizens' rights and the drive for profit as part of the capitalist economies it serves.

Indeed, the role of the Canadian state has been identified as being closely linked to the workings of the economy, which change over time and within particular contexts. "So, for example, in the periods following World War II, the various levels of the Canadian state could be described as relatively autonomous from corporations and as seeking to limit the negative consequences of markets. Today, the state openly arranges partnerships with corporations and works to enshrine markets through international agreements" (Armstrong, 2001, p. 3). Through partnerships with private industry as well growing emphasis on international trade and competition, the Canadian welfare state is very much tied to the workings of the economy.

Liberal ideology and commitment to industry influences not only the types and extent of entitlements provided to its citizens, but also who may be able to receive such entitlements. Thus, the market and the state have tremendous power and influence over the lives of Canada's citizenry. The relationship between the market and the state may uphold (or reduce) social inequities and sustain advantage or disadvantage among certain groups and influence class relations. Thus, we can see that the economy is not an abstract force, but is embedded in relations between people and the state (Clement, 1999).

2.4 Political Economy and Inequality

Although emphasis on and understanding of the relationship between the liberal welfare state and the economy necessarily differ among political economy perspectives (liberal, social democratic or conservative), class relations as they are created or maintained through the economy and their interactions with the state are of central

concern within the political economy perspective[3]. Given that class and class relations are a central focus of many political economists, it is useful to outline how class positions are understood within the contemporary capitalist economy, as the nature of the market itself plays a key role in class formation.

Globalization and technological advances are often attributed to changes in the postindustrial economy and consequently, class formation and relations (Esping-Andersen, 1999). National business classes lobby in defense of the virtues of a free market economy, arguing that a market free of state interventions is necessary in order to remain competitive. Liberal welfare states such as Canada, which are heavily influenced by the demands of the market and encourage commodification, may be more apt to assume such a view. Indeed, critics maintain that the adoption of such a neoliberal ideology on the part of governments is central in understanding continuing inequalities among those in varying class positions:

> The most important causes of the growth in inequalities are political, such as the implementation of neoliberal public policies by neoliberal and conservative (and on occasion, social democratic) governments and the consequent weakening of the labour movement and trade unions; the fiscal policies implemented by these governments; the decentralization of collective bargaining agreements and the weakening of universal social policies (Navarro, 2002, p. 70).

As noted above, these ideological beliefs have real implications in terms of the nature of production and class relations. The foundations of North American economies have shifted from the production of goods to the production of services that involve low wages and low-skilled work. "In North America, the strength of organized labour is split along the public private divide. The public sector is typically highly unionized, while organized labour is virtually absent in private services" (Clement and Myles, 1994, p. 247). The consequence of this decline in unionized workers relates to one of the suppositions of power resource theory. For those in the working or lower classes, the only compensating political power they have in relation to the power of the corporate elites is

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[3] Given the sheer breadth of political economy it is not possible to discuss all possible theoretical understandings of the relationship between the state and the economy. As such, this discussion will be limited to a political economy approach that applies Esping-Andersen's (1989, 1990, 1999) understanding of the liberal welfare state, which Canada has been identified with, and a power resource model which understands that class relations are shaped and influenced by both the economy and the state, and that social welfare provisions are the result of both political and economic forces.

through organization and unionization. The decline of unionism attributed to globalization and the changing nature of labour may have profound implications for the political power that the working classes have and consequently, the entitlements that those of lower class positions may be afforded through the state.

In recent years, in the name of fiscal responsibility and the need to remain competitive in a global economy, the state has reduced funding to existing social services and created or extended eligibility criteria for others. "The reasoning is that too much redistribution, equality and social protection reduces individuals incentives and impairs the market's ability to furnish an adequate number of jobs" (Esping-Andersen, 1999, p. 175).

Eligibility criteria and relatively modest social programs are not new to Canada. As a liberal welfare state, Canada places greater emphasis on the market and has been more heavily influenced by liberal work ethic norms than other (e.g., socialist democratic or corporativist) welfare state regime types (Eping-Ansersen, 1989). Social welfare policies and programs in Canada are often based on one of two types of social assistance programs - income related benefits and benefits that are based on perceived need. In the case of income related benefit programs, such as the Canada Pension Program and Employment Insurance, it is thought that entitlement to benefits should be based on a worker's contribution to that program through paid labour. However, participating in the paid labour force is not enough to determine eligibility. Often, as in the case of Employment Insurance, the distribution of benefits is based on criteria such as hours worked, and income. Thus, those who earn the most (generally white, upper or middle class men) benefit the most from these types of social welfare programs, while those in the working classes who earn less in the labour force and are more likely to be underemployed or experience interruptions in paid employment, generally do not benefit from them to the same degree (Benoit, 2000). The second type of social welfare program is based on perceived need. Financial need is often based on a means test (Acker, 1988). Although eligibility criteria vary among different programs and policies, poverty and lack of private insurance are often the primary determinants of the receipt of social welfare benefits (Acker, 1988). However, these benefits are typically modest, associated with

stigma, and cater to those with already low incomes resulting in "an equality of poverty" (Esping-Andersen, 1999).

Both income-related benefits and benefits associated with perceived need may be seen as reflections of the concept of the 'deserving' and 'undeserving' within society. The assumption inherent in programs that are based on prior earnings is that: "social mobility is possible through individual effort; individual liberty is preserved, and opportunities are accessible to all" (Olson, 1982, p.12). Those with higher-class status receive a greater share of social welfare benefits when needed (such as greater employment insurance and pension benefits) and are more likely to be afforded private insurance through their position in the labour market (i.e. disability insurance, health benefits) than those in the lower middle or working classes. The differences among classes in relation to rights and entitlements afforded may be attributed not only to differences in the valuation of labour in the market, but also to the state. Thus, the state is not a neutral entity, but is seen as a central apparatus in supporting and maintaining social inequalities associated with class divisions.

2.5 The Feminist Critique of Political Economy

Most political economists also recognize that the effects of class may be amplified by gender inequalities within the formal labour market (Clement, 1999; Clement and Myles, 1994; Esping-Andersen, 1999). In an effort to account for gender, some political economists have begun to include women as a focus of their analysis in addition to class (Clement and Myles, 1994; Esping-Andersen, 1999). However, this effort has not gone without criticism. In recent years, an increasing number of feminists have pointed to the exclusion of women and women's work in a conventional political economic perspective.

Feminists such as Dorothy Smith (1992) argue that a traditional political economy approach is itself embedded in the ruling apparatus of capitalism. "The central relevancies, assumptions, methods and conceptual practices of the political economic discourse remain largely unchanged by attempts to embed feminist topics into the discourse" (1989, p. 38). Smith (1992) argues that the social sciences have assumed that 'the main business' of the economy is the accumulation of capital, omitting production

and reproduction that takes place in what is now recognized as the informal economy. Thus, simply adding women to the analysis rather than creating an analysis in which women and women's work are central, does not effectively produce an analysis that incorporates women and women's roles into the theoretical discourse.

In an effort to create a political economy that includes gender and gender relations, feminists have attempted to outline a more comprehensive feminist economy approach. The basis for this merger is the common ground that they see political economy and feminist viewpoints sharing: "Political economy, like feminism, sees social relationships as conditioned by economic social structures and processes. It also understands economic arrangements in turn as determined by power relations that are maintained and reproduced through ideological control" (Luxton and Maroney, 1987, p. 6).

2.6 The Formal and Informal Economy

A feminist political economy approach recognizes gendered distribution. Personal relations (such as marriage), the wage, and the state are all locations of gendered distribution (Luxton and Maroney, 1987).

Although women's participation in the paid labour force has drastically increased over the past forty years, and the incomes of women have become increasingly important to the maintenance of the family, there is still the assumption that the earnings of the wife in a marital relationship are a secondary wage, and therefore her employment and consequent economic autonomy are often sacrificed when care needs arise. While this argument is clearly flawed as male wage earners have experienced significant declines in real income over the past twenty years and the 'family wage' has largely become a thing of the past, women remain at a disadvantage in the labour force, and social policies have been created and upheld because of the roles and values that have been assigned to gender (Benoit, 2000; Clement and Myles, 1994; Maroney and Luxton, 1999). As noted earlier, reductions in social programs have profound implications for the lives of women within the formal and informal economies and personal relations. "Women are in and out of the labour force depending upon the needs of their children and aged parents, the

vagaries of their husband's job location, etc" (Gee and Kimball, 1987, p.62). Thus, traditional gender roles and divisions of labour associated with the home and marriage compounded with reductions in social services available, limits women's income potential and career opportunities.

The wage gap has also long been a feminist concern. "Women as wage earners are, because of their lower social status, more poorly paid" (Ritzer, 1996b, p. 321). Despite denials that the wage gap is a thing of the past, quantitative evidence suggests that it is alive and well. "Canadian males in full-time, full year employment in 1996 still earned an amazing $10,000 - plus more per annum than female counterparts" (Benoit, 2000, pp. 73-74). This inequity exists no matter what level of education has been obtained, resulting in women making an average 75% of what men do in similar occupations (Benoit, 2000, pp. 73-74). This form of gender inequality helps to reproduce women's disadvantaged social position.

Forces of globalization and postindustrialization have also affected women's work. One such impact has been 'the feminization of class structure'. "The feminization of the labour force means that in modern capitalism the 'worker' has two prototypes rather than one: the male, blue-collar worker of industrial capitalism and the postindustrial, female service worker" (Clement and Myles, 1994). Traditionally, Canadian women were most likely to find good high paying, unionized positions through the public sector (Maroney and Luxton, 1999). However, public sector restructuring has meant that Canadian federal, provincial and municipal governments have all tried to cut spending on social services, in part by privatizing delivery of these services. The result has been that the types of employment that afforded women the most economic and political power have been eroded and been replaced by private sector positions. "In the private service and sales sector, where job growth has occurred, a high ratio of labour to capital means that profits are made by control of the total wage bill, through low pay rates or a flexible workforce. Largely as a result of employers' opposition, these jobs have low rates of unionization, and, even if unionized, tend to have poorer wages and fewer benefits" (Maroney and Luxton, 1999, p. 95). It is women who are disproportionately represented in these types of service sector industries (Benoit, 2000; Luxton and Maroney, 1999).

Further, the postindustrial economy has resulted in 'flexible employment', essentially meaning interruptions in employment in response to the ebbs and flows of the market as well as an increasing number of part-time workers (Clement and Myles, 1994). This has profound implications for women, not only in relation to potential earnings, but also in their ability to qualify for income-related benefits such as employment insurance, and eligibility for union membership.

Unlike a traditional political economy approach, which places emphasis on state-market relations alone, a feminist political economy approach recognizes the value of all labour, and it's contribution to the economic cycle of production and reproduction. "All variants of political economy now recognize that what goes on in the household has economic significance" (Luxton, 1987, p. 18). In a capitalist economy, we generally assign value to paid labour. As domestic work is unpaid, it generally carries minimal value in a society that equates worth with economic recompense. While domestic labour may carry little economic value, it is seen as indispensable for the reproduction of social and economic life. The division of labour in the home is generally unequal; with women performing more labour intensive tasks as well as assuming more responsibility within the home. The first point of discussion is that domestic labour is important to both social and economic reproduction. Meg Luxton defines social reproduction as:

> All activities involved in daily reproduction-the provisioning of people to ensure they eat, sleep and get other material and emotional sustenance they need to stay alive and keep going from day to day. This includes care for the ill, elderly or otherwise dependent people. Social reproduction also includes intergenerational reproduction-the biological production, socialization and care or children. (Luxton, 1998, p. 58).

For Canadians, social reproduction goes on in family-based households, which depend on income from paid work to ensure their livelihood. Thus, part of sustaining life on a daily and generational basis includes the production and reproduction of people, who need to be, or are attached to the labour market. This makes social reproduction an important element of the production and reproduction of the capitalist economy. Although social reproduction is a necessary element of capitalism, it is also at odds with it. "Employers need workers but have no immediate interest in how workers live, nor whom they support with their earnings" (Luxton, 1998, p. 58). Employers therefore have

an interest in the production of capital, not necessarily how the social reproduction of capital takes place. As a result, the labour associated with social reproduction, caring labour and household maintenance is devalued within the Canadian economy. The implication of this devaluation of labour is that the political power that women who work within the home are able to extend is limited and consequently, social rights and entitlements are generally not extended to those outside of the formal economy.

2.7 Women and the State

A substantial feminist literature has emerged over the past twenty years that challenges many of the assumptions surrounding mainstream state theorizing. "The traditional scholarship has focused on state-market relations but paid little attention to the family, stressing the significance of class, but neglecting gender" (Evans and Werkele, 1997, p.8). In particular, feminists have critiqued the absence of gender in the power resource model and Esping-Andersen's typology of welfare states that emphasizes the political nature of the struggle to secure social provisions (Benoit, 2000; Evans and Werkele, 1997; Lister, 1990).

Benoit (2002) argues that mainstream perspectives on welfare states implicitly assume that the state is a gender-neutral entity, and that welfare provisions have a similar bearing on both men and women. Further, feminists argue that this model also assumes that the greater the distribution of resources in a society, the greater the level of equality among inhabitants. "Many feminist writers maintain that the wage earner/breadwinner/citizen discussed in mainstream perspectives, whether stated explicitly or implied, is almost always considered to be male. This holds true for the most recent contributions focusing on comparative welfare states (Esping-Andersen, 1990; Esping-Andersen and Korpi, 1987)" (Benoit, 2000, p. 21). The assumption in these models that economic independence is essential for full citizenship and that employment (or class) is the chief distinctive feature of the (male) worker. The relationships between class, the welfare state, and capitalism are prominent within this approach, while the family, seen as another domain of inequality among feminists, has been ignored. While the link between paid work and welfare has been emphasized, the welfare regime type

breaks down when unpaid work is taken into account. Thus feminists argue that to reflect adequately the position of women, an understanding of stratification must move from a focus on class relations alone to incorporate attention to the way that the state may privilege the male 'worker/citizen status' (Benoit, 2002; Evans and Werkele, 1997; Luxton and Maroney, 1999).

Further, feminist scholars have argued that women's social, political and civil citizenship rights are premised on correcting two major obstacles to women in capitalist countries: inadequate wages and unequal access to jobs, and economic dependence on others (men and the state) due to inordinate caring responsibilities for children and dependent others (Benoit, 2000, p. 21). The contention is that relations of domination are based on control of women in the family, the workplace, and public spaces which undermines women's abilities to participate as "independent individuals – citizens- in the polity, which in turn affect their capabilities to demand and utilize social rights. The way the state intervenes, or refuse to, are critical to women's situations" (Orloff, 1993, p.309). Thus, a feminist political economy approach recognizes the role of the state as well as the market in creating and maintaining patriarchy as well as class divisions.

Like a traditional political economy approach, social policy is seen by feminist political economists as reflecting the dominant ideologies and belief systems that enforce, bolster and extend the structure of advantage and disadvantage in the larger economic, social and political order. As noted earlier, these ideologies are reflected through social policies and programs that attribute rights and entitlements based on class status. Feminist political economy argues that many social policies and programs have been founded on the male breadwinner model. "Many women have been incorporated into the welfare state through entitlements as wives. While mainstream analysis has totally neglected this basis of entitlement, feminists have underlined its significance - placing it in a larger framework of the gendered division of labour in the family and society" (Sainsbury, 1996, p. 49).

In the male breadwinner model, family ideology celebrates traditional forms of marriage and the nuclear family form. The husband is seen as the head of the household, and the wife as responsible for caregiving and household labour. This division of labour has been codified into law, social and labour legislation as well as the tax system (Evans

and Werkele, 1997). The unit of benefit is the family, and the presumption of a family wage, earned solely by the husband. Eligibility for receipt of these benefits is based on breadwinner status and maintaining the existing social norm. This allows for wives to become dependents within marriage. As a result, married women may lack individual entitlement to benefits. In the Canadian context, such benefits may include the Canada Pension Plan that is based on participation and wage earned within the paid labour force, or similar programs like Employment Insurance and Workers' Compensation (Mossman and MacLean, 1997, p.128).

Social policy is also seen as mirroring inequalities in social structure and the outcomes of power struggles around those structured arrangements (Smith, 1985). As such, social policy is not gender neutral. Rather, it reflects the advantages and disadvantages of capital and labour as well as men and women. Within the workforce, women are more likely to work in service or caring occupations that are characterized by low pay and underemployment. As noted earlier, those of lower class statuses are either less likely to receive the same level of compensation in terms of some social welfare programs, or receive meager benefits from others. Women are also more likely to participate in unpaid or domestic labour than are men (Benoit, 2000; Evans and Werkele, 1997; Lister, 1990; Maroney and Luxton, 1987, 1999). Unpaid labour is generally not valued in the formal economy. As a result, rights and entitlements associated with labour and labour power are not afforded through the state.

Further, some feminists argue that the changes associated with the forces of globalization and postindustrialism may have had a particularly negative effect on women in the realm of social policy and welfare (Benoit, 2000; Evans and Werkele, 1997; Maroney and Luxton, 1999; McDaniel, 2003). "Public sector restructuring has meant that Canadian federal, provincial and municipal governments have all tried to cut spending on social services, in part by privatizing delivery. As public services erode, women in general have picked up as unpaid labourers, many of the services previously provided by hospitals, child care centers and other state agencies" (Maroney and Luxton, 1999, pp. 94-95). The rationale for these cuts to particular social welfare programs is located in an ideology of personal and familial responsibility. This has profound implications for women, as they are the most likely to access these services (Evans and

Werkele, 1997) and the most likely to have to fill the gaps that the reductions of these services have left with their unpaid labour. There is a societal expectation that caring is a natural female characteristic and therefore women are the most appropriate source of caring labour (Evans and Werkele, 1997; Hooyman and Gonyea, 1999; McDaniel, 2003).

McDaniel argues that these changes are a direct result of a neoliberal ideology that is upheld to meet the interests of capital and the state. "Neoliberal models of care, by contrast, focus on the marketization of caring as beneficial to the public agenda of fiscal restraint. The paradox here is that the economy benefits substantially and knowingly from the unpaid caring work of women. In Canada, unpaid caring is estimated to outstrip the value of paid services by a ratio of three or four" (McDaniel, 2003, p. 140). Thus, although the goal is to offset costs by placing responsibility on the family to provide these types of services, it is women who are disproportionably affected by these changes, which are a result of power relations and traditional gender roles and divisions of labour.

2.8 The Aging Critique and the Development of a Political Economy of Age

Although a feminist political economy accounts for the unique experiences of women and women's relations with the state, the formal and informal market economies and the home, to date both mainstream and feminist political economists have tended to neglect age and age relations (McMullin, 1995, 2000). "In view of the growing recognition of the importance of gender in later life, the lack of theoretical development concerning the relationship between gender and aging seems incomprehensible" (McMullin, 1995, p. 30). This is an important omission given that social experiences, an individual's role in both formal and informal economies, their political position, rights and entitlements and how they are affected by social policy all vary by one's location in the life course.

Much like the feminist critique of mainstream political economy, social gerontologists maintain that age cannot simply be added on to existing political economy theories. Feminists have argued that to simply add women to existing theories negates the unique experiences of women and women's work (Benoit, 2000; Maroney and Luxton, 1999; Smith, 1992). The same may be said of age relations. Much like class and gender

relations, age relations are seen as being socially produced. The experience of growing old is seen as a social construction in that it is neither unalterable nor given by external reality (Estes, 1999). How old age is regarded is socially constructed by those with influence as well as prevailing cultural, economic and political forces and consequently shapes how old age and older adults are processed and treated within society (Estes, 1999). Although social status in later life is often influenced by earlier employment, it is also affected by other factors such as retirement and by inequalities explicitly associated with old age such as discrimination in the formal market economy and social welfare policies that are exclusively targeted to older adults (McMullin, 1995).

To simply add age to existing paradigms risks homogenizing the aging experience and further reinforcing the idea of difference based on age, rather than the differential experiences associated with age as a result of social constructs. "First, in these paradigms, social life is assumed to vary according to the particular characteristic that is to be added to an established theory. In other words, rather than treating social life as organized and structured around a particular set of relations, like age relations, these theories use age as a variable that is the basis of difference" (McMullin, 2000, p. 34). Further, McMullin (1995) argues that this emphasis on difference assumes an ideal type, which is most often a white middle-class male.

Although there are a number of theories that have dealt explicitly with age and age relations, past paradigms dealing with the experiences of older adults have been problematic for social gerontologists interested in a critical gerontology. Many researchers have argued that theoretical perspectives such as disengagement theory, the life course perspective, and age stratification theory[4] are highly individualistic theories which do not adequately address issues surrounding structural inequalities and stratification (Estes, Swan and Gerard, 1984; McMullin, 1995, 2000; Walker, 1980). In response to the absence of age as a central concern in both mainstream and feminist

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[4] The underlying proposition of age stratification theory is that all societies group people into social categories based on age, which provides social identities and determines the distribution of resources (Quadagno and Reid, 1999). Age stratification theory was criticized for ignoring power relations that determine how statuses and roles were allocated. It also neglected the fact that age (although a source of social identity) had less of an impact on life chances than other dimensions of stratification, and that older adults were not a homogenous group, but rather experienced difference based on ethnicity, gender and class. Thus, while age stratification theory does address inequality, it does not address power or emphasize structural foundations of that inequality.

political economy theorizing as well as critiques of existing gerontological theories, scholars such as Peter Townsend (1981, 1986), Chris Phillipson (1982) and Alan Walker in the United Kingdom (1981, 1987, 1990, 1991) as well as Carroll Estes (1979, 1982, 1991, 1999) and Laura Katz Olson (1982, 1993) in the United States and John Myles in Canada (1984, 1989), began to apply a political economy perspective that had age as a central concern.

The central objective of a political economy of aging is to analyze the structural characteristics and interrelationships of the state and the economy in the distribution and allocation of the resources, which may maintain or create inequality in old age (McMullin, 2000; Quadagno and Reid, 1999). "Hence, political economy theories focus on social structural explanations of inequality rather than on individual reasons such as the natural diminishing physical or mental capacities of older people" (McMullin, 2000). Thus, the central argument of a political economy of aging is similar to that of mainstream and feminist approaches in that it sees social relationships as conditioned by economic social structures and processes, and understands that economic arrangements are determined by power relations, often exerted through the state, which are maintained and reproduced through ideological control (McMullin, 1995, 2000; Quadagno and Reid, 1999). However, a political economy approach to aging recognizes that age relations, like gender and class relations, are organized through structural conditions, and that those in different age groups will have different experiences within the market, the welfare state and the home.

2.9 Age and the Economy

The welfare state is generally given primacy within a political economy of aging perspective. Although the economy remains central in shaping the experiences and social location of older adults in later life, discussions of the role of the economy in shaping the experiences of older adults tends to be limited. This is primarily because older adults are generally not involved in the paid labour force, and consequently, not directly involved in processes of production and reproduction. As a result, most discussions surrounding the role of the economy within this perspective revolve around its impact on social policy and welfare initiatives, or on pre-retirement class status.

Given that experiences in old age are shaped by politics, the economy and social location, a political economy perspective on aging demands attention to class. However, there are difficulties in applying class to the aged. Most importantly, the non-employed aged are not generally defined as a 'productive' sector of the economy. One strategy political economists have used is to use a life course framework to assess the class relations of older adults based on their pre-retirement class status. The argument here is that power relations and resources in late life are shaped by people's earlier class location.

However, as McMullin (2000, p. 522) points out:

> Missing in these accounts is an analysis of the relationship between age relations and class relations as they structure inequality in later life. As others have pointed out (Kohli, 1988; Myles, 1980) the economic and social locations of older people reflect not only class inequalities in later life but also unique processes that are structured by age relations.

Additionally, since the majority of older adults are women, if class in old age is solely defined in relation to pre-retirement class status, many women, especially those who never have participated in the paid labour force, may be excluded or inaccurately considered to be of their partner's class status.

In an effort to deal with class status among those who are not directly involved in the formal relations of production, Estes (1999) has argued that class itself must be redefined from a more traditional framework that surrounds participation in the paid labour force to a definition that considers the commonalities shared by groups of individuals based on the economic foundations of society. "Class is characterized by a coherent social and cultural existence; members of a class share a common life style, educational background, kinship networks, consumption patterns, work habits and beliefs" (Estes, 1999, p. 23). This definition may be particularly useful in application to the aged as it considers the social and economic relations that continue into old age despite the lack of participation in the paid labour force while still considering such resources as property ownership and income which are the foundation of class relations.

McMullin (2000) argues that this understanding of class ignores the relations of production and distribution, and does not consider relations or the processes involved in inequality. "Rather, as in stratification research, its goal seems to be to assess difference

on the basis of categorizing people according to similar life situations" (McMullin, 2000, p. 522). In an effort to account for inequalities in the principles of distribution, John Myles (1989) has argued that income inequality in old age is a product of the state, rather than the market. However, following a power resource model, Myles sees pension entitlements as a result of the political mobilization of the working class as defined in Marxist terms. Myles (1989) has argued that age relations are formed by power relations that are played out within the state, which influence the current social location of older adults through postretirement pension schemes and social welfare programs. Income in later life may be a better expression of inequality and class relations than traditional notions of class. However, this matter is far from resolved within the theoretical discourse.

Further, when discussing class in old age it is also important to note that older persons of every class are seen as being at a disadvantage in relation to their younger counterparts. "The ownership of wealth without effective control over investment and physical means of production leaves even the wealthy elderly on the periphery of the class dynamics of the larger society" (Estes, 1999, p. 24).

When discussing the relationship between class and older adults, the focus once again turns to the welfare state. As older adults in general, and older adults in lower classes are afforded less political or economic power, they will be affected more severely by reductions in social welfare services. Those in lower socioeconomic or class statuses who are often the most in need of these services. For example, poverty, income inequality and class have been directly linked to higher levels of morbidity, disability and chronic illness (Humphries and Doorslaer, 2000; Navarro, 2002, Mustard et al., 1997; Poland et al., 1998). In general, this is attributed to the fact that those living in poverty, among the working classes or among those with fewer resources in relation to others in a society, have greater exposure to various social and economic risk factors associated with poor health, such as inadequate nutrition, lack of leisure time available, poor work environments, low levels of education and unhealthy lifestyles (smoking, drinking, etc.) (House, Landis and Umberson, 1988). While poor health may reflect an accumulation of exposure experienced over many years, the impact is not lessened by age, those living in

poverty experience illness more often and of a more serious degree leading to increased morbidity (Robert and Fawcet, 1999).

2.10 Age and the Welfare State

Given that the welfare state is a central location of political power, organization and distribution among many older adults, it plays a central role in a political economy approach to aging, and is seen as essential in understanding the production and reproduction of social inequalities (Estes, 1990, McMullin, 2000). Although the welfare state is comprised of many social, political and economic institutions that make up the social order, "researchers from the political economy of aging perspective generally equate the state with the governing bodies responsible for the policies relating to social welfare" (McMullin, 2000, p. 520). Thus, much like mainstream and feminist perspectives, a political economy approach to aging assumes a conflict paradigm in relation to state theory, arguing that the welfare state is not a neutral entity, but plays a role in the production and reproduction of social inequalities (Estes, 1999). However, a political economy approach to age places greater emphasis on social policy as an expression of power relations than either mainstream or feminist theoretical approaches to political economy.

The importance of the welfare state and social policy to older adults is underlined by the fact that much of the research within the political economy of aging perspective has focused on how the welfare state has sustained inequality among an older cohort through policy interventions that emerge in the context of a capitalist society. "A core assumption of the political economy approach is that public policies for income, health, long-term care, and social services are an outcome of the social struggles and dominant power relations, which are not merely components of private sector relationships, but are also adjudicated within the state" (Quadagno and Reid, 1999, p. 348).

Indeed, many political economists have argued that the welfare state, through social welfare policies, has itself shaped our understanding of age. "Several political economists have argued that the transformation of old age based on chronological age was made possible by the establishment of a set of age-based pensions administered by

the state and that old age has come to be defined in terms of retirement" (McMullin, 2000, p. 521). Alan Walker (1981, 1991, 1999) has argued that segregative social policies such as retirement have come to define who is no longer useful to the process of production at a particular point in time. "The effect of this exclusion is to depress the status of elderly people relative to younger, productive adults and to sustain inequalities between different groups among the elderly" (Walker, 1981, p. 89).

The removal of older workers from the formal labour force at a fixed age regardless of ability is legitimated by institutional social policies. "Governments use age as a regulatory mechanism to establish eligibility for particular statuses and benefits" (Street, 1999, p. 110). The creation of a fixed age barrier to employment is seen as contributing to older adults' economic dependency on the state and reduction in political representation and power, as employment is not only a primary source of income in capitalist societies, it is also a source of social status and the basis for participation in a wide range of roles and relationships (Estes, 1999; Irwin, 1999; Walker, 1981, 1999).

One of the products of this reduction in both economic and political power is that the income needs of older adults are typically seen as lower than those who are 'economically active'. Thus, public pensions are set at rates that are considerably lower than the average earnings of adults who participate in the paid labour force (Estes, 1999; Walker, 1981, 1999). In addition, given older adults' dependence on the state as a primary source of income, and their role as 'unproductive citizens' within the capitalist economy, these developments are seen as having encouraged the view that aging is a social problem and older adults are an economic burden. "In short, the aged are seen as parasitic on the state, and ultimately, on wage-earning taxpayers...elderly people have been 'welfareized', that is, seen primarily in terms of their needs as recipients of various forms of welfare" (Arber and Ginn, 1991, p. 263). Indeed, despite evidence that the majority of older adults are able to function in relative independence (Keating, 1999), a conceptualization of old age as a period of absolute dependency, illness and functional decline, which is leading towards an economic crisis as the population ages, has emerged (Arber and Ginn, 1991; Aronson, 1999; Clark, 1999; McMullin, 2000; Myles, 1980; Olson, 1982).

Some political economists have argued that the crisis ideology surrounding 'the apocalypse of the baby boom' has been perpetuated by the state in order to meet the demands of capital (Myles, 1980, McMullin, 2000; Olson, 1982). Much like mainstream and feminist approaches, a political economy of aging recognizes the relationship between the formal market economy and the liberal welfare state. As noted earlier, liberal welfare states such as Canada, which are heavily influenced by the demands of the market, may be more apt to adopt a neoliberal ideology. The central argument of the 'crisis of old age' or the 'apocalypse of the baby boom' is that as the population ages and increasing numbers of older adults claim a larger share of resources, both in the form of pension schemes and increased utilization of health care services, the economic burden of providing for the aged will bankrupt modern societies. Theorists have argued that the adoption of this 'crisis' mentality has resulted in reductions in funding for social welfare programs such as health care and pension schemes which disproportionately affect older adults (Armstrong, 2001; Chappell, 1993; Gee, 2001; Williams et al, 2001).

Further, given that Canada is a liberal welfare state that affords primacy to the market, social welfare policies and programs targeted to older adults are typically based on income related benefits or benefits based on perceived need. As noted earlier (p. 20), income-related benefits such as the Canada Pension Plan are founded on an ideology of entitlement based on a worker's contribution to that program, and are seen as mirroring ideological differences among those of privilege and those without. In contrast, social assistance programs based on need generally provide subsistence level benefits and are allocated to older adults who are unable to live on their retirement wage. Unlike income-related benefits, there is no underlying assumption of entitlement. As a result, the definition of 'need' may vary from program to program, and may be altered to meet the interests of government.

In the demand to reduce social welfare expenditures in recent years, social policies have become increasingly restrictive. "Struggling under huge cutbacks and threats of closure, government funded social work agencies servicing elderly people, have had little choice but to incorporate streamlined service models which refocus programs on the notion of the deserving elderly – that is "targeting" services only to the most needy" (Brotman, 1998, p. 167). Those who are seen as 'able', must purchase these

services through the private sector, assuming that they are available given that the private sector bases its involvement in such programs on profitability.

Although class remains an important element of a political economy on aging, much like mainstream theories, gender has remained conspicuously absent from much the theoretical discourse. Although it is widely acknowledged that intersection of class and gender are important in the discussion of age and inequality, few theorists have addressed these concerns (McMullin, 2000).

2.11 Intersections of Age and Gender

Much like mainstream approaches, political economy perspectives on aging have been criticized for their lack of attention to intersections of class and gender (Arber and Ginn, 1991; McMullin, 1995, 2000; Quadagno, 1999). Although some political economists concerned with aging have assessed differences between men and women (Arber and Ginn, 1990, 1991, 1995; Olson, 1982), "Estes (1991, 1999) is the only political economist that who has systematically attempted to theorize gender" (McMullin, 2000, p. 523).

Estes (1991, 1999) draws upon prior feminist literature that argues that class relations are gendered, and argues that while women of all classes are seen as marginalized in some way through patriarchy, their experience of that marginalization differs by social class. Further, Estes (1999) contends that women are more likely than men to be in a lower class position. The inequalities that women face in accessing education, full time continuous employment, equal wages and positions with high levels of pay and adequate benefits carry through into post retirement (Brotman, 1998; McDonald, 1997; Norris et al., 1999). The ramifications of these inequalities may include lack of access to a livable wage from a pension because of low or no contributions, inability to work after the age of sixty-five because of constraints (to earn a wage in addition to pension benefits) such as mandatory retirement and age discrimination in employment, and as a direct consequence of gender inequalities that make it difficult to access resources.

Given that older women are also more likely to have participated in unpaid work, they do not possess the political power that may be associated with class position and pre-retirement employment. Pre-retirement income and class, as expressed through property ownership and access to material and social resources, influence resources that are available to older adults after retiring from the paid labour force. Given that women are frequently dependent upon their partners' incomes throughout the life course and into old age, it is expected that should those partnerships end, the class status of female spouses will decline.

Further to this, the absence or withdrawal of existing services may also be seen as perpetuating inequalities along class and gender lines. Much like younger women, older women provide a disproportionate amount of care to others within the home (Keating, 1999). The reduction of social services in the form of in-home care or other social welfare programs may further increase their work in the home, particularly among those women without the financial resources to access assistance privately.

Thus, Estes (1991, 1999) argues that gender and class are interlocking systems of oppression. However, as McMullin (2000: 523) has pointed out, "despite the latter claim, Estes often reverted back to documenting differences between men and women, classes and young and old without thoroughly considering the intersections among these sets of power relations". Consequently, intersections between age, gender and class remain problematic.

2.12 Applying a Political Economy Approach on Aging to an Examination of In-Home Care

As noted throughout this discussion, the central objective of a political economy approach to aging is to analyze the structural characteristics and interrelationships of the state and the economy in the distribution and allocation of the resources, which may maintain or create class, gender, and age-related inequalities in old age (McMullin, 2000; Quadagno and Reid, 1999).

While traditional political economy approaches have emphasized the relationship between the state and the economy in shaping class relations, feminist political economy has focused on gender relations and both the formal and informal economies, whereas a

political economy on aging has attempted to emphasize the role of the state in creating or maintaining inequalities along the intersections of age, gender and class. However, all variants of political economy are concerned with power relations.

Further, all three political economy perspectives discussed share the understanding that the economy plays a fundamental role in shaping class relations. Although a feminist political economy also places emphasis on gender relations within the formal economy, it also recognizes the value of all labour and it's contribution to the economic cycles of production and reproduction. A political economy approach focusing on age also sees the economy as a contributing factor in how age itself is perceived, as well as shaping class and gender relations.

All three variants of political economy noted here share the view that the state is not a neutral entity, but rather the state is seen as a system of stratification that orders and directs social relations. Esping-Andersen's (1989, 1999) typologies of welfare states have been highly influential in understanding the development of the welfare state in capitalist economies. Esping-Andersen (1989, 1990, 1999) has argued that welfare states must be compared in relation to their commitment to granting individual social rights to participate in the community as a full citizen rather than on state expenditures for welfare provisions. Although some feminist political economists (Benoit, 2001; Evans and Werkele, 1997; Luxton and Maroney, 1999) have argued that this understanding of the welfare state assumes that the state is gender neutral and that welfare provisions have a similar bearing on men and women, most feminist political economists also recognize the importance of Esping-Andersen's identification of Canada as a liberal welfare state which places greater emphasis on the market and has modest social welfare provisions which are generally means tested forms of assistance. Although all three political economy perspectives presented here share the view that social policy mirrors social inequalities, feminist and aging perspectives have placed more emphasis on social policy as a form of stratification than a more traditional approach.

It has been argued here that postindustrial economies resemble their industrial counterparts in that there remains a small ruling class. However, power relations as opposed to the relationship between the worker and the means of production, are perceived as the central force in shaping class relations. However, one of the key ways in

which postindustrial economies differ is in their emphasis on capital mobility and free trade which are seen as the foundations of economic globalization.

Some political economists (Coburn, 2003; Navarro, 2002) have argued that the process of economic globalization has led to increased pressures on the state from large multinational corporations to adopt neo-liberal policies in order to be more competitive in the global market. As Coburn (2003: 28) puts it: "The essence of neoliberalism, in its pure form, is an adherence to the virtues of a free market economy and, by extension, market oriented society". Political economists (Coburn, 2002, 2003; Navarro, 2002, Poland et al., 1998) have argued that this shift in political ideology in relation to the role of the state in the market has had a profound influence on the relations and conditions of work (Armstrong, 2001; Benoit, 2000; Evans and Werkele, 1997; Navarro, 2002) and has resulted in cutbacks and the restructuring of social welfare programs and policies (Armstrong, 2001; Benoit, 2000; Coburn, 2002; 2003; Evans and Werkele, 1997; Navarro, 2002).

Although understandings of the relationship between the liberal welfare state and the economy differ among political economy perspectives, class relations as they are created and maintained are a central feature of all of the political economy perspectives presented here. Within a traditional approach, class formation and relations in a postindustrial global economy are the central focus. It has been argued that liberal welfare states such as Canada have been heavily influenced by the demands of the market, and have adopted a neo-liberal ideology. This is seen by some (Coburn, 2002, 2003; Navarro, 2002) as central to an understanding of class-based inequalities. They argue that the strength of unionized labour has been weakened and that service sector jobs carrying few benefits and little union protection has resulted in a loss of political power on the part of the working classes. The adoption of a neoliberal ideology on the part of the state, combined with the loss of political power on the part of the working classes, has allowed for a dismantling of the welfare state. Through its emphasis on the market and reduction of services aimed at those in the working class, the state is seen as a central apparatus in supporting and maintaining social inequalities.

Feminist political economists also emphasize class relations. However, a feminist approach to political economy differs from a more traditional perspective in that it places

gender, in addition to class as a core concern. Much like traditional approaches, feminists see the workings of a postindustrial global economy and the state as central to understanding inequality. Feminists have argued that the forces of globalization and industrialization have had profound implications for women and women's work. The increase in low paying service sector jobs which are not generally unionized and are characterized by interruptions in employments to meet the demands of the market have had a deleterious affect on women's working lives. However, unlike a more traditional approach, a feminist political economy recognizes the value of all labour. The division of labour in the home is generally unequal, with women assuming more responsibility within the home than men. Although unpaid labour in the form of social reproduction and caring work is essential to the workings of the economy, it remains largely unvalued.

A feminist political economy recognizes the role of the state in perpetuating and maintaining social inequalities. Social policy is seen by feminists as reflecting the dominant ideologies and belief systems that reinforce and extend the structure of advantage and disadvantage. Indeed, within the feminist perspective, the role of social policy in shaping women's experiences has been a central concern. It has been argued that the liberal welfare state, which emphasizes the market and the allocation of means-tested forms of social welfare, reinforces disadvantage among women who are more likely to experience lower incomes, interruptions in employment or work within the informal economy (Benoit, 2000; Maroney and Luxton, 1999; Mossman and MacLean, 1997; Sainsbury, 1996). Postindustrialism and the forces of globalization have also had an effect of women in the realm of social policy and welfare. A neoliberal agenda has emphasized reductions in social welfare spending. The result of this is that caring services, which were once provided for by the state, are now increasingly the responsibility of the private sector. Women are disproportionately affected by these reductions, as they are the most likely to access these services as well as to fill the gaps left by these types of service reductions.

Although a traditional political economy approach recognizes class relations as a central concern, and a feminist political economy focuses on the intersections of gender and class, both these approaches have neglected age and age relations. The central objective of a political economy of age is to analyse the structural characteristics and

interrelationships of the state and the economy in the distribution and allocation of resources that may maintain or create inequality in old age.

Although the welfare state is generally afforded primacy within this approach, a political economy of aging recognizes the role of the economy and class relations in shaping the experiences of older adults. However, as many older adults are not generally defined as part of a 'productive' sector of the economy, there have been problems in applying class status to older adults. One strategy political economists have used is to use a life course framework to assess the class relations of older adults based on their pre-retirement class status. However, since the majority of older adults are women, if class in old age is solely defined in relation to pre-retirement class status, many women, especially those who never have participated in the paid labour force, may be excluded or inaccurately considered to be of their partner's class status.

In an effort to deal with class status among those who are not directly involved in the formal relations of production, Estes (1999) has argued that class must be redefined so as to consider the commonalities shared by groups of individuals based on the economic foundations of society. However, McMullin (2000) argues that this understanding of class ignores the relations of production and distribution, and does not consider relations or the processes involved in inequality. Although, the measurement of class status is far from resolved within the theoretical discourse, it is important to note that older persons of every class are seen as being at a disadvantage in relation to their younger counterparts as they are afforded lesser political and economic power. Consequently, they will be affected more severely by reductions in social welfare services, as it is those with lower socioeconomic or class status who are often the most in need of these services.

This has profound implications for the discussion of health and access to in-home care services as poverty, income inequality and class have been directly linked to higher levels of morbidity, disability and chronic illness (Humphries and Doorslaer, 2000; Navarro, 2002, Mustard et al., 1997; Poland et al., 1998). In general, this is attributed to the fact that those living in poverty, among the working classes or among those with fewer resources in relation to others in a society, have greater exposure to various social and economic risk factors associated with poor health, such as inadequate nutrition, lack

of leisure time available, poor work environments, low levels of education and unhealthy lifestyles (smoking, drinking, etc.) (House, Landis and Umberson, 1988). While poor health may reflect an accumulation of exposure experienced over many years, the impact is not lessened by age, those living in poverty experience illness more often and of a more serious degree leading to increased morbidity (Robert and Fawcet, 1999).

Further, like other approaches discussed, a political economy on age recognizes that the postindustrial economy and the forces of globalization have profound implications for older adults. Some political economists (Myles, 1980; McMullin, 2000, Olson, 1982) have argued that the crisis ideology surrounding the aging of the population has been perpetuated by the state in order to justify the adoption of a neoliberal ideology leading to service reductions, including health care programs. Given that it is older adults, particularly those in lower class positions that are likely to be in the greatest need of these services, it is argued that they will be affected more severely by reductions in home care services.

Similarly, the experiences of older women will vary from those of men, both in terms of the how social welfare policies are constructed and implemented, and in terms of their political and economic power. According to this view, class relations are themselves gendered, and the structural inequalities that women face throughout the life course in the market and the state carry through into post retirement (Brotman, 1998; McDonald, 1997; Norris et al., 1999). Given that class and income inequality are associated with a greater need for health services, the construction of health policy may disproportionately affect women. Further, older women provide an unequal amount of care to others within the home (Keating, 1999). Thus, eligibility for in-home care services, which is determined through the state and articulated through social policy, may further increase women's unpaid labour in the home, particularly among those women without the financial resources to access assistance privately. This too may be seen as an articulation of power relations reproduced through the welfare state.

Although class remains an important element of a political economy on aging, much like mainstream theories, gender has remained conspicuously absent from much the theoretical discourse. Although it is widely acknowledged that intersection of class and gender are important in the discussion of age and inequality, few theorists have addressed

these concerns (McMullin, 2000). Estes (1991, 1999) has been cited as the only political economist who has systematically attempted to theorize gender, class and age relations (McMullin, 2000). However, as McMullin (2000) has pointed out, Estes has often reverted back to documenting differences between men and women, social classes and young and old without thoroughly considering the intersections among these sets of power relations. Consequently, intersections between age, gender and class remain problematic.

As noted earlier, although a number of existing theories have dealt explicitly with age and age relations, past paradigms have been problematic for those interested in a critical gerontology. It has been argued that perspectives such as disengagement theory, the life course perspective, and age stratification theory are highly individualistic, and consequently do not adequately address issues surrounding structural inequalities and stratification. Thus, despite the limitations surrounding the theoretical development of intersections between class and gender, a political economy approach offers a unique perspective with which to guide this study.

Researchers employing a political economy perspective to age have typically examined how perceptions of age may have influenced the formation of public policy (Townsend, 1986, 1986; Townsend et al., 1988), analyzed public policy as an expression of the dominant medical discourse (Estes, 1999), examined policy over time in order to identify how the state may maintain or create inequality among older adults (Myles, 1984) or explicitly examined state-market relations in the creation of inequality (Coburn, 2002, 2003; Navarro, 2002), seeking to prove the validity of political economy as an existing theoretical framework. However, the use of a political economy approach in this study does not address systemic patterns of inequality articulated through the development of public policy relating to in-home care, nor does it examine British Columbia's Continuing Care policy in relation to historical changes.

The primary rationale for the use of a political economy approach in this study is as a lens through which we may see the social world. As a critical theory, political economy draws attention to how public policy, which is shaped by state and market forces, may negatively impact upon the lives of older adults. Similarly, a political economy perspective demands attention to inequalities along class and gender lines,

recognizing that the experiences of men and women will vary by their social location. In this way, a political economy approach may be used to inform the type of questions asked and analyses conducted in regard to access to in-home care services.

Having recognized the limitations associated with examining intersections of class, gender and age, we may now proceed to discuss how a political economy approach on age may be applied to an examination of how the workings of the state and the economy may contribute to inequalities faced by older adults in access to specific services such as in-home care.

In order to determine if and the extent to which the state, through in-home care policy, sustains or increases inequalities along class and gender lines, we must first examine health care policy at the national level. A brief history of the formation and framing of health care policy in Canada will be presented. Next, the influence that the global economy may have had in shaping current health policy on a national level and how this has impacted upon current provincial health policy will be examined. The focus of the discussion will then centre on how the current framing of in-home care policy may have a disproportionately negative impact upon older women and those in the working classes.

Chapter 3: Review of the Literature

3.1 Health Care Policy in Canada

To fully understand the implications of changes to national health policy and how the forces of globalization and postindustrialization may have impacted upon the distribution of resources and health coverage as it relates to in-home care services in British Columbia, a brief history of Canadian health care policy is necessary.

At the time of Confederation in 1867, neither income security nor social service programs were considered to be the responsibility of the federal government. The British North America Act (BNA) did not include welfare measures and the government's contribution was limited to poor relief administered at the local level (Deber et al., 1998; Mahtre and Deber, 1999; Segall and Chappell, 2000). Generally, speaking, health was considered a private domain, and formal health care was provided primarily through volunteers, or financed through private expenditures. In relation to health, the BNA act assigned responsibility for quarantine centres and marine hospitals as well as the health care of 'special groups' such as those in the Armed Forces and veterans (Deber et al., 1998; Segall and Chappell, 2000). As Segall and Chappell (2000, p. 209) note, this was significant because any jurisdiction not specifically assigned to the federal government necessarily fell within the provincial domain.

Several authors (Deber et al., 1998; Segall and Chappell, 2000) attribute the way that health and health care were treated to historical events. Public acceptance of medicine occurred in the early part of the twentieth century (Segall and Chappell, 2000). With the discovery and introduction of vaccines and a better understanding of the causes of disease, medicine gained credibility, and the income and status of the medical profession increased. Medicine was subsequently regulated and licensing laws were passed. At this time, private enterprise dominated the health care field. "Doctors, dentists and nurses sold their services privately. Drugs and medications were sold on the market, and physician prescriptions were not required" (Segall and Chappell, 2000: 210).

The great depression showed that events beyond the control of the individual could profoundly affect their ability to obtain private health services. Further, the revelation that many men could not participate in the war effort due to poor health

revealed the costs of inadequate health care resources and exposed the vulnerability of many private schemes. These events resulted in a series of commissions, task forces and reports, which concluded that the risks and determinants of illness were relatively easy to predict and reasonably constant. In these reports, it was argued that all Canadians should have equal access to health care despite their class, socioeconomic standing or geographic location (Chappell et al., 2003; Hollander, 1999). "The expansion of the role of the Canadian government in the health field after the second world war marked a fundamental shift in social and political values, which must be understood as the context for current debates about the public-private mix in the health system" (Deber et al., 1998, p. 458).

In 1942, Dr. Leonard Marsh's report "On Social Security for Canada" called for a comprehensive national system of social security, including insurance for sickness, old age, disability and maternity. Marsh argued that the Canadian government had a moral responsibility to provide citizens with a basic level of social services and income support (Deber et al., 1998). "It began to be argued that government involvement would provide greater public access to needed health services and would thus benefit individuals (who received the services), providers (who were guaranteed to be paid for them), and society as a whole (through a more healthy population)" (Deber et al., 1998, p. 458).

However, many researchers have argued that structuration of Canada's health care system was shaped by the credibility and legitimacy given to medicine as well as the power of those in the medical profession (Segall and Chappell, 2000). In the economic upturn after the depression, hospitals emerged as a location of complex medical procedures. While the hospital was once viewed with fear, they now came to be seen as places where skilled medical interventions were practiced, and were no longer viewed as places where the poor went to die (Segall and Chappell, 2000). Those in the medical community were perceived as 'experts' surrounding the determinants of health and illness and consequently, how illness should be treated and defined (Estes, 1999). A medical model of health holds that: diseases are universally recognizable through objective measures and pathology does not vary across time, space or culture and that disease is caused by unique biological forces such as microorganisms. This model also holds that most appropriate treatment of illness and disease is through a technical

approach and neutral scientific processes (Segal and Chappell, 2000). "Therefore, as a nation, Canada has structured its health care system with a primary focus on the treatment and cure of acute conditions – on the delivery of health care services that are primarily medical in focus, physician dominated, and centered in acute care hospital settings" (Penning, 2002, p. 294). Thus, health care in Canada became equated with medical care.

In 1947, Saskatchewan became the first province to introduce universal hospital insurance in recognition of the fact that the expenses associated with hospital care could be financially devastating. Other provinces gradually followed suit. These provincial developments culminated with the passage of the federal Hospital Insurance and Diagnostic Services Act, where the federal government agreed to share the costs of hospital care and diagnostic services with any province that established an insurance program that complied with national conditions (Deber et al., 1998, p. 458). All provinces had signed on by 1961.

In 1962, Saskatchewan once again took initiative and introduced an insurance plan that covered physician services for medically necessary procedures (Deber et al., 1998). The provincial government asserted its authority to be the sole insurer, but allowed physicians to retain their private practice. Thus, while the system was publicly administered, physicians remained private entrepreneurs. The introduction of the Medical Care Act in 1966 established similar conditions and funding schemes across the country. By 1971, all provinces had complying plans, meaning that hospital and medical insurance was available to all Canadians.

However, the federal government saw the cost-sharing program as too open-ended and inflexible, and in an effort to control costs, they changed the way health care was funded in 1977 (Deber et al, 2000; Mhatre and Deber, 1999; Segall and Chappell, 2000; Williams et al., 2000). Prior to this date, the federal government paid 50% of all approved provincial health care expenditures (hospital and physician services), while the provinces retained control of the administration and delivery of health care (Deber et al, 2000; Segall and Chappell, 2000). "However, the federal government increasingly expressed its desire to control the continually escalating costs of health care, while the provinces more and more showed their dissatisfaction with the federal direction in an area of provincial jurisdiction" (Segall and Chappell, 2000: 211). Thus, in 1977, a new

system of cash grants, based on a formula that included population size, GNP and tax credits from the federal to the provincial government replaced cost sharing (Clark, 1999; Deber et al, 2000; Segall and Chappell, 2000).

This was seen as easing federal costs associated with health care, and providing provinces with more control because these transfers were no longer dependent on the use of specified services (Segall and Chappell, 2000). However, as provincial health care costs increased, some provinces responded by implementing extra billing and user fees (Segall and Chappell, 2000). As concern over 'reasonable' access and the future of universal health care coverage grew, the federal government enacted legislation in the form of the Canada Health Act in 1984 (Deber et al, 2000; Segall and Chappell, 2000).

The foundation of the Canada Health Act is encapsulated by five promises in relation to coverage surrounding hospital services, diagnostic tests and physician services: universality, comprehensiveness, portability, accessibility and public administration (Chenier, 1999). The Canada Health Act establishes the criteria and conditions related to insured health care services - the national standards - that the provinces must meet in order to receive the full federal cash transfer contribution under the Canadian Health and Social Transfer[5]. Thus, this act provides for a reduction of federal financial contributions to provincial health plans equal to the amount of extra billing and user fees should they be applied. It also provides a minimum set of requirements for the provincial health insurance plans to meet; anything above these requirements is at the discretion of the province.

In 1986, the Canadian Health and Social Transfer was amended to reduce the rate of growth to federal contributions, with further reductions taking place in 1989, 1990 and 1996 (Segall and Chappell, 2000, p. 211). "From 1979 to 1994, federal transfers as a proportion of total health expenditures fell from 31.6 percent to 21.9 percent" (Deber et al., 1998, p. 474). Political economists often see this reduction in federal investment in the Canadian health care system over the 1980's and 1990's as a result of global pressures to reduce state expenditures, reduce debt and pay down deficits and increasing

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[5] The Canada Health and Social Transfer is a block payment to the provinces from the federal government in support of hospital and medical insurance programs defined by the Canada Health Act, as well as postsecondary education and programs formerly funded under the Canada Assistance Program (Derber et al., 2000).

pressures exerted through international agreements such as the North American Free Trade Agreement to privatize health services (Coburn, 2002; Deber and Williams, 1995; Williams et al., 2000). "The changing economic context of recession or international competition is often given as explanation for the contemporary restructuring or downsizing of health care or for threats to the principles of Medicare from forces pushing for privatization" (Coburn, 2002, p. 47).

Deber, Baranek and Williams (1995) note that among OECD nations, Canada's costs, although high in international terms, were perceived as 'out of control' largely because Canada never recovered from the recession of the early 1980's. Further, Keating and Cook (2001) argue that in addition to high government debt and a low Canadian dollar (including health care), apocalyptic demography (that we cannot afford an aging population) has also been used in order to justify major cost-cutting initiatives in the public sector in order to reduce welfare state expenditures.

Indeed, although the timelines varied among provinces, the federal government intended to eliminate transfer payments altogether (Segall and Chappell, 2000). Deber and Williams (1995) argue that this offloading of costs to the provinces was a product of the dual role of the state in meeting the needs of capital and the interests of citizens:

> As a guardian of societal interests, it has a variety of policy goals: ensuring quality care, minimizing total costs, appeasing public sector unions, improving cost-effectiveness and efficiency of care delivery, maintaining a robust economy, improving equity, maintaining political popularity and so on. As a payer, the major policy aim is far simpler – to minimize government paid costs. The easiest way to control government costs, of course, is to shift them to someone else. (Deber and Williams, 1995, p. 298)

Although the elimination of federal transfer payments to the provinces may have lessened federal expenditures, it also led to a loss of federal power in the ability to oversee and regulate health care. "This course of action removed any power the federal government had (as stated in the Canada Health Act of 1984) to prevent provinces from charging user fees or extra billing" (Segall and Chappell, 2000, p. 211). In 1999, in a time of economic surplus and in response to growing discontent among Canadians with the gradual withdrawal of the federal government from health care, the federal government

announced that federal funding in the form of transfers would once again be implemented (Segall and Chappell, 2000).

However, a number of critics argue that the reduction in federal investment in health and social service spending has resulted in a loss of power on the part of the federal government to regulate and control Canada's health care system (Aronson, 1998; Baranek, Deber and Williams, 1995; Keating and Cook, 2001; Mhatre and Deber, 1992; Segall and Chappell, 2000). Indeed, Aronson (1998: p.117) asserts that: "with the introduction of the Canada Health and Social Transfer, the federal government has relinquished its role in framing and enforcing national standards in health care".

3.2 Home Care Policy in Canada

Although provincial health plans ensures that all Canadians have reasonable access, without direct charges, to all hospital and physician services deemed medically necessary, in-home care and support services typically have been excluded from public insurance. This may in part be attributed to the evolution of health and social policy in Canada (Hollander, 1999).

Much like hospital and physician services, other forms of care for the poor, sick or mentally ill prior to the Second World War were seen to be the responsibility of the family, religious and volunteer organizations (Hollander, 1999). Although formal home care services emerged in the late 1800s and early 1900s with the work of the Victorian Order of Nurses, who provided homemaking services and in-home nursing care, individuals and families had to pay directly for these types of care services (Hollander, 1999).

Publicly subsidized home care services were first introduced in Canada in the 1950s as pilot programs. However their intention was not to serve as a form of health promotion, to delay or replace long-term residential care among older adults, but rather they "tended to offer medical services only, primarily as a means of shortening hospital stays" (Penning, 2002, p. 300). It was during this time frame that the first national health care insurance program was being established.

However, given the credibility, legitimacy and power given to medicine and the medical community at the time, and the emphasis placed on acute illness and cure rather than on prevention, home care and home support services were not included in the Hospital Insurance and Diagnostic Services Act (1957), the Medical Care Act (1966) nor integrated into the Canada Health Act in 1984.

The exclusion of in-home care services under the Canada Health Act means that although the existence of universal health insurance entitles chronically-ill patients to access to hospital and physician services without charge, many health and support services fall within the range of the social welfare system and are not subject to the terms and conditions of the Act (Deber and Williams, 1995). "The Act's definition of comprehensiveness requires coverage of all medically necessary services delivered in hospitals or by physicians. Home care, with the exception of physician visits, therefore, need not be insured" (Baranek, Deber and Williams, 1999, p. 70). Consequently, in-home care services have tended to be developed as add-ons to existing institutional care (Chappell, 1993), and services vary from province to province in terms of eligibility for coverage, care services available, and whether and to what extent service fees are charged (Aronson, 1998; Clark, 1999; Baranek, Deber and Williams, 1995; Deber et al., 1998; Penning, 2002).

Despite the fact that home care was identified as a priority for funding in the 1997 federal budget; as well as being emphasized in a National Forum on Health report in 1997 (Neysmith, 1998) and the focus of a national conference in 1998 (Wilkins and Beaudet, 2000), the federal government is unable to compel provinces to provide publicly subsidized in-home care services as a result of the exclusion of home care services under the Act. Further, the federal government has substantially reduced the amount of health care funding given to the provinces.

In response to federal reductions in health care funding, as well as the perceived crisis of an aging population needing increasingly more care, provinces have increasingly expressed need to change the health care system in order to reduce costs. Over the past decade for example, "virtually every province had established enquiries, commissions, and other committees to examine the cost-efficiencies within their health care system" (Segall and Chappell, 2000, p. 244).

Provinces have generally responded to concerns surrounding escalating health care costs in two ways. First, as hospitals represent the largest single expenditure within the health care system, provincial governments responded by reducing the number of hospital beds allocated to chronic care patients, freezing or reducing hospital budgets, the closure of hospitals altogether and placing moratoriums on building long term institutional beds (Chappell et al., 2003). Second, in an effort to reduce hospital admissions, shorten hospital stays and delay or prevent costly institutionalization, provinces began to emphasize community based care. "During this period, there were no increases or only minor increase to acute care hospital budgets, with small increases in community and home care budgets in many provinces" (Chappell et al., 2003, p. 420).

Some argue that the shift to community has meant that governments are afforded greater flexibility in deciding which services will be funded, the criteria that must be met in order to receive care, and how it will be provided, making it possible to limit the availability of care without violating the Canada Health Act's principals of universality, comprehensiveness and accessibility (Williams et al, 2000). Additionally, as in-home care services are not explicitly protected under the Canada Health Act, there are no restrictions surrounding the privatization of non-medically necessary services within the home (Norris et al., 1999).

However, given the variation of in-home care policy amongst provinces, the remainder of the discussion of the role of the welfare state in the creation of social policy (specifically relating to in-home care services) will focus exclusively on British Columbia.

3.3 B.C.'s Home Care Policy in the Context of Health Reforms

In 1991, the Royal Commission on Health Care and Costs set the agenda for health care reform in B.C. (Vogel, 2000). Specifically, it concluded that the goal of health care reform in the 1990's, should be to shift resources away from crisis intervention and acute illness, toward prevention, early intervention and health promotion, bringing health care 'closer to home' (Vogel, 2000). The shift of emphasis from acute care services to in-home care services was justified for two primary reasons; the first was tied to cost.

The Seaton Commission (1991) noted that 70 percent of all health care costs are paid for through the provincial government, and that the provision or expansion of health care services was only possible through the growth and strength of the provincial economy. "If the provincial economy is healthy, then government revenues will be ample and the health care system can maintain itself or expand without straining financial resources. But if the economy stagnates or declines, the government's revenue is reduced and some combination of deficits, increased taxes and program cutbacks follows" (Seaton et al., 1991, p. 10).

At the time of the Commission's report (1991), the provincial economy was experiencing a decline in economic growth. Although the period between the 1960s and 1970s was a time of sustained growth in the provincial economy, the 1980s saw a period of recession, and during the time of the report, the province had once again run into deficit (Seaton et al., 1991). As one of the central concerns of the Commission was to examine cost-efficiencies within the provincial health system, cost cutting measures were of primary concern. Indeed, the Commission concluded that: "If slow overall growth continues through the 1990s and no changes occur in the organization and delivery of health services in BC…the money available for health care will only increase if the province goes further into debt, or increases taxes" (Seaton et al., 1991).

At the time (1991), hospitals consumed almost half of the Ministry of Health's $5.4 billion dollar budget (Seaton et al., 1991). The commission concluded: "The appropriateness of hospital use and the proper scope and scale of the hospital sector are, therefore, major issues for health care in BC" (Seaton et al., 1991, p. 31). The Commission carried out research, which suggested that patients were kept in hospital too long, or placed in hospital when long-term residential care would have been more appropriate, and more cost efficient. Further, it argued that technological changes, including advances in pharmaceuticals meant that many of the services that were once provided in hospital, with the exception of specialized medical interventions, could now be provided less expensively within the home (Williams et al., 1999).

The second argument tied to the expansion of in-home care was driven by the belief that 'home care is the best care'. "Services provided "closer to home" can enhance consumer choice, independence and quality of life, impacting positively on health and

well-being" (Williams et al., 1999, p. 126). Indeed, the Commission presented these proposed changes not only as an efficient form of cost cutting, but also as a change in philosophy of care (Seaton, 1991). The commission concluded that as increasing numbers of British Columbians had chronic conditions that could best be care for at home or in supportive, non-acute facilities, and that the emphasis on care should shift from acute interventions, to long-term support, health promotion and prevention (Vogel et al., 2000).

Thus, the Seaton Commission (1991) recommended hospital downsizing with the proviso that the money saved from this restructuring be reallocated to community level care. Between the years of 1988 to 1996, there was a gradual decline in the proportion of the provincial health care budget assigned to medical and hospital services and increases in the proportion of the budget allocated to continuing care services (Penning et al., 1998).

However, Segall and Chappell (2000: p. 244) cite findings indicating that within continuing care: "the proportion of the budget that is expended on home care services (that is, non-nursing services only) increased in the early years but declined in the later years. Similarly, the number of clients served and the number of hours of services provided to home care clients increased in the early part of the period but declined more recently". Findings also suggest that although fewer people were receiving in-home care services, the intensity of services provided to those who did receive services increased, and that those who were receiving services were in greater need as measured by level of care (Segall and Chappell, 2000). Further, research indicates that hospitals dealt with bed closures and reductions in funding by reducing the average length of a patient's stay, not by reducing admission rates. The use of day surgery also increased (Vogel, 2000; Wilkins and Park, 1998). As Vogel (2000: 25) puts it: "People are simply being sent home sicker and quicker". These findings imply that there has not been a fundamental shift in the philosophy of care toward one which emphasizes prevention and promotion, but rather that procedures and forms of care that were once considered medical in nature have simply moved into the home.

Researchers have argued that the continued focus on acute or medical care (as opposed to forms of care which promote independence and health maintenance) disproportionately affects older adults, and are tied to the dominance of the medical

model (Aronson, 2000; Estes, 1991, 1999, 2000; Clark, 1999; Olson, 1993). For example, Estes (1999) argues that the power of medicine and the 'medical model' approach to care is articulated through public policy and has influenced policymakers' understandings of health-related need. "Public policy regarding medical care for the elderly clings to a medical engineering model, which constructs health and illness based on a rational system of causes within the context of the body's cellular and biochemical systems. This model implies that it requires an expert (such as a physician) to fix problems, usually after they occur" (Estes, 2000, p. 47). Due to the emphasis placed on cure rather than management (care) or prevention of illness within this model, the focus of resources is placed on medical interventions and cure, rather than social, preventive and non-medical interventions and care despite compelling evidence of their benefits (Aronson, 2000; Hall et al., 1992; Townsend et al., 1988).

Thus, although the original mandate of the Continuing Care Act was to support adults who have needs arising from a long-term health related condition, critics fear that in-home care services are being used as a substitute for acute care services, rather than care whose goal is health promotion and prevention (Segall and Chappell, 2000). "The expansion of services to the acutely ill under home care has led to a shift in priorities. Especially with capped home care budgets, there is widespread concern that the acute hospital discharge group has been driving out those who need social and personal rather than medical services" (Baranek, Deber and Williams, 1999, p. 86).

However, not all political economists see these developments as solely attributable to the dominance of the medical model. Some political economists have also argued that transferring the locus of care from the province to the community has been done not only to satisfy the political interests of reducing health care expenditures, but also to 'profitize' health care (McDaniel, 2002; Williams et al., 2001). Williams et al. (2000, p. 15) frame it the following way:

> Even if public health care remains, by continuing to restrict coverage to 'medically necessary' services, while pushing care outside of hospitals through bed closures and by refusing to cover new drug therapies that reduce the need for invasive surgery and hospitalization, neo-liberal governments can ensure that a growing portion of the health field, like any other commercial field, is 'open for business' to global competitors (Williams et al., 2001).

Indeed, within British Columbia, Vogel (2001) found that gaps in public Community and Continuing Care services are creating opportunities for private firms to enter. "Several large firms have been aggressively investing in residential and long term care in B.C. in recent years. The three fastest growing corporations CPL Long Term Care, CPAC (Care) Holdings, and Ishtar Seniors Communities have seen dramatic revenue gains" (Vogel, 2001, p. 42).

Thus, despite claims that health reforms are necessary in order to accommodate an aging population, as older adults are more likely to experience functional decline associated with long term chronic illness (Chen and Wilkins, 1998; Wilkins and Park, 1996), health reforms which do not adopt a broader view of health and treatment or which continue to emphasize acute care, are not well suited to an older population. Further, it has been argued (Williams et al., 2001) that these types of reforms are not aimed at improving the overall health and well being of Canadians as health care users, or improving the way health care is delivered in Canada. Rather, the purpose of health care reforms is to meet the interests of the provincial government in reducing expenditures, and multinational corporations in increasing profit margins.

3.4 Home Care Policy and Reliance on Informal Care Providers

The aging of the population and concerns surrounding government expenditures in recent years has led to debate about the ability of governments to provide formal care services to frail seniors. According to Keating et al. (1997), as a result, a new paradigm has emerged. "The subtext of the new paradigm is the belief that the amount of public support previously provided to frail seniors is no longer affordable, and that more responsibility for eldercare must be carried by informal caregivers and by seniors themselves" (Keating et al., 1997, p. 25). Many of the services that currently fall under the umbrella of home care or home support services have a high degree of what has been termed 'substitutability', meaning that many of these services, with the exception of

specialized medical interventions, may be provided by informal care providers[6] (Aronson, 1998).

Thus, in order to reduce spending, most policies regarding the long-term care of older adults have focused on families as the ones to provide much needed care services. "The idea is that the best care is responsive to the needs of older adults and that informal caregivers are in an ideal position to provide this responsive care since they know the senior best" (Harlton, Keating and Fast, 1998, p. 281). Indeed, most of the care and support that seniors receive is provided through informal care networks. Estimates place the amount of care provided to seniors by informal networks at 70-90% of all care received (Keating et al., 1999). Further, studies have revealed that those with the greatest levels of informal support are the least likely to access formal care services (Chen and Wilkins, 1998; Mutchler and Bullers, 1994; Wilkins and Beaudet, 2000; Wilkins and Park, 1998). It remains unclear however whether this is due to the fact that the older adult's care needs are being met, or is attributable to policy frameworks that consider the availability of care networks when allocating care services despite actual care needs, the resources of the care providers or the appropriateness of informal care.

Although informal care networks play an important role in maintaining the independence of many seniors, the provision of informal care alone may be problematic. There has been an extensive literature produced over the past several decades which suggests that there can be real emotional, physical and even financial consequences to both the care provider and recipient (Aronson and Neysmith, 1997; Fast and Keating, 2000; Keating et al., 1999). As people are sent home increasingly ill, informal care providers may be poorly equipped, unable or unwilling to meet intensive care needs, placing the health of the recipient of care at risk (Glazer, 1990; Guberman and Maheu, 1999). Further, there is evidence that the assumption that older adults themselves prefer family care to formal in-home care services may be inaccurate. "Although family members and policy makers believe that informal caregivers should be the first line of

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[6] Informal supports include 1) an intimate or confidant relationship (like a spouse or partner), 2) family and close friends and 3) community individuals (such as neighbours, work colleagues or casual friends) (McColl and Friedland, 1994, p. 61). In essence informal social networks, which may offer forms of emotional and instrumental support or informal care, are characterized by spontaneous relationships rather than through referral or formal processes that characterize formal care services

defence in providing eldercare services, older adults do not necessarily view family care as the first choice" (Aronson, 1998, p. 282).

While family members provide the majority of assistance with instrumental activities to older adults, friends also play an important role in the caregiving networks of many seniors. Barrett and Lynch (1999) found that the size and composition of helping networks varied significantly among married and non-married older persons, with those who were widowed, single or divorced more often relying on friends for instrumental assistance than those who were married. A Canadian study by Keating et al. (1999, p. 20), supports such findings: "Unmarried seniors may be among the most vulnerable to social isolation and at greatest risk for having unmet needs for care because they are most likely to be without strong family ties". This may be cause for concern, especially among older women who are more likely to be widowed than men and lack the intense personal care that is often provided by a spouse (Segall and Chappell, 2000). Findings indicate that the care friends provide is often less consistent than care provided by family members. Himes and Reidy (2000) found that those who provided care to a friend are generally older, unemployed and provided care for fewer hours. Unlike family members whose caregiving is seen as a stable and long term relationship, friends' caregiving is generally short term and limited to care of acute rather than chronic illness. "As the survival rate for many chronic disabling conditions improves, friends may be less likely to adopt the caregiving role" (Himes and Reidy, 2000, p. 331). This has clear implications for an aging population that may not have access to supportive family members. Thus, although informal care networks are essential in retaining the independence of many seniors, reliance on such networks to provide care that was at one time provided formally may be problematic.

A political economy approach to aging which places gender as a central concern, argues that policies structured based on the assumption that family and friends are the best-equipped and most appropriate sources of care, shifting the responsibility for care from public to private, disproportionately affects women (Armstrong, 2001; Estes, 1991, 1999; McDaniel, 2002; Norris, 1999). It is well-documented that women provide the majority of care to others throughout the life course (Armstrong, 2001; Aronson, 1998; Benoit, 2000; Estes, 1991, 1999; Keating, 1999; McDaniel, 2002; Williams et al., 1999).

The provincial government's position regarding the division of public and private is best articulated in a recent policy document examining the implementation of compensation for family caregivers. "Compensating family caregivers would represent a fundamental shift in the balance between family and the state with respect to responsibility for the care of persons with disabilities. Such a shift would increase the notion of entitlement to funding for what has always been considered primary responsibility of the family" (Interministry Committee on Compensation for Family Caregivers, 2002, p. 20). Thus, according to this document, the provision of care to the disabled has always been the responsibility of the private sector, and has not been included as part of an overall view of health and health care. This clear division of public and private responsibilities not only assumes that there is someone available to provide care but also, that care needs which stem from long-term chronic health conditions are not the responsibility of the Canadian health care system. Further, McDaniel (2002, p. 136) argues that: "if caring is compelled, out of women's fear that if they do not care no one will, the compromise becomes greater for the women's own life prospects, for the person needing care, and for the society that demands care, but does not reward it".

Indeed, recent research indicates that there are real financial implications associated with shifting the onus of care from the public to the private sector (Aronson and Neysmith, 1997). "Claimed as cost reductions in public accounting, such cuts represent cost increases for family carers" (Aronson and Neysmith, 1997, p.48). As patients are returning home sooner, there are inevitable costs associated with the care that was once provided in hospital. These costs may take the form of time off work, or paying for equipment and prescriptions that may not fall under the provincial jurisdiction for coverage, or that payment for certain services and medical needs must be made immediately, to be reimbursed later. Further, the costs of caring are not limited to younger women. Older women provide a substantial amount of care to their spouses, despite often having their own health-related care needs (Benoit, 2000; Hooyman, 1999; Keating et al., 1999; McDaniel, 2002). Many older couples, by virtue of living on a fixed income, may face undue financial burden in providing care in the home.

These costs too have different implications for those in differing social classes. Clearly, the potential costs of this unpaid caring unfold differently for both men and

women in different social locations. "Those with more resources, by virtue of class, race or age will be better able to offset the costs of caring, whether by purchasing private help or by being able to negotiate public resources from a more privileged position" (Aronson and Neysmith, 1997, p.51).

Thus, a political economy approach on aging and care maintains that governments which adopt a neoliberal view of the roles of the welfare state and family, shift the onus of care from public to private through social policy, not because older adults prefer family care, but rather to meet the interests of the market in reducing social welfare expenditures and increasing opportunities for profit-making (Aronson, 2000; Baines et al, 1998; McDaniel, 2002). In the process, the welfare state may be creating or maintaining inequality among men and women, and those of varying class status.

3.5 The Organization and Delivery of Home Care in British Columbia

In order to fully examine whether and how the state may perpetuate inequality in relation to access to in-home care services, it is useful to begin with a short outline of the conceptualization of continuing care services in British Columbia, including discussion of the needs assessment process.

Home care and home support services were introduced to the province in 1978 as part of the Continuing Care program. The mandate of Continuing Care Services is to support adults who have needs arising from a long-term health related condition (British Columbia Ministry of Health, 2000, p. 2). Continuing Care is a term that is generally used to describe a system of service delivery that includes long-term care, home care and home support services. According to Hollander and Walker (1988: p.3) "It is important to note that Continuing Care is, in fact, not a type of service, such as hospital care or physician services, but a complex system of service delivery. For example, although long-term care may encompass many of the services that are provided under the label of home care and home support services, long-term care may be provided not just in the home but also within an institutional setting (Hollander and Walker, 1998, p. 3). Continuing care, as a service package, may be short term should the needs of the client change, whereas long-term care implies that the individual suffers from a chronic illness

that will demand care over a long period of time. Thus, although long-term care and continuing care sound similar, a distinction between the two may be made on the basis of permanency.

In Canadian provinces, home care encompasses home nursing care, rehabilitation services, therapeutic services and home support services (such as housekeeping). In British Columbia, however, home care services refer to only community home nursing care and a community rehabilitation program (which provides consultation, occupational therapy and physiotherapy treatment services to homebound clients upon referral from physicians and hospitals - British Columbia Ministry of Health, 2000). The provision of such services is by health care professionals (such as nurses and physiotherapists) and is consistent with a medical model of care. As such, these services are provided directly through government in keeping with the Canada Health Act.

Home support services, in contrast, are generally provided by persons other than professionals and are not part of the home care program. Their aim is to assist clients with health related disabilities continue living in their homes (Hollander, 1993). Home support services are provided by home support workers who are required to attend a 22-week community college program with a provincial curriculum. In essence, home support is supposed to be a preventive measure against institutionalization and increased physical decline for those needing assistance with both instrumental and basic activities of daily living. In British Columbia, services that are available under the umbrella of home support include a meals program[7], housekeeping and personal care such as assistance with bathing, toileting and grooming. Such services, while not medical in nature, are considered important in promoting health and independence (Vezina and Roy, 1996). Thus, in many cases, home support services are useful to persons who, while not acutely ill, may experience functional limitations, which hinder their ability to remain in their homes independently. However, these services are not seen as 'medically necessary' and care providers are not perceived as 'medical professionals'. As such, these services tend to be excluded from coverage under the Canada Health Act.

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[7] This is a voluntary community service that provides and delivers hot meals to the elderly. There is a charge of six dollars per meal. The regional health authority organizes this program

British Columbia has a single entry system that uses assessments and case managers to determine what types of care are most appropriate and who may access them. Assessment activities include: intake and screening, initial assessment, program planning and authorization, monitoring, evaluation follow-up, and reassessments. In order to access either home care or home support services, clients must go through an assessment process indicating the level of care needed. A caseworker determines what services the individual is eligible for based on that assessment.

The assessment instrument, referred to as the LTC1, is used across the province and places potential home nursing care and home support clients into one of five categories based on level of assessed need for services (Continuing Care in British Columbia Fact Sheet, 2000). The highest level of need is extended care. People assessed as needing extended care services are those who need help to walk and transfer themselves in and out of a bed or chair. These individuals have ongoing medical problems, which require 24-hour per day nursing care. Extended care is provided in acute care hospitals, extended care facilities and private hospitals (Hollander and Walker, 1998). While extended care is not provided in-home, it is managed by the continuing care system; therefore extended care beds are considered to be part of that system.

Intermediate levels of care are classified into three different components: IC1, 2 and 3. Intermediate 3 care (IC3) is the second highest level of care. In some cases, this care is provided in extended care facilities. However, it also may be provided in-home. This level of service is designated for those with high level of care needs but who may not need 24 hour a day care, or whose family is providing the client with some of their care. Intermediate 2 care (IC2) is aimed at those who need some personal and home support services as well as some in-home nursing or rehabilitative care. Intermediate care level 1 (IC1) is provided to those who have lesser care needs, but suffer from some long-term chronic illness that limits their functional ability. In this case, some home nursing services may or may not be provided in addition to home support services. Personal care is the lowest level of care need. In this case, generally only home support services such as meal preparation and home cleaning are needed to assist with functional limitations that may be associated with long-term chronic health concerns, such as arthritis. Nursing services are generally not required.

Community home nursing care and community rehabilitation services are only available upon referral from a physician as well as completion of a needs assessment. Eligibility is based on health status, residency and citizenship. Often, the recipients of such services are not required to pay for any of the service delivered. Eligibility for home support services is based on health status, age, residency and citizenship. However, a physician's referral is not necessary. There is some ambiguity surrounding the role of informal social networks in determining eligibility for home support services. Although a Health Canada (1999) report as well as a web site outlining benefits to seniors in British Columbia (1998) suggest that the availability of informal social support is considered as part of the assessment process in relation to eligibility for in-home care services, the amount or availability of informal social support is not included as part of the eligibility criteria in the Continuing Care Health Act. Additionally, it remains unclear how the level and availability of informal social support is considered as part of the assessment process. Although the LTC1 (shown in Appendix A) makes note of a contact person, one who assists with the application for services or who is willing to maintain an interest in the client's welfare, no other family information is requested. With regard to health status, individuals must have had a chronic illness for a minimum of three months to be eligible. Unlike home nursing services, user fees based on an income test that is standard across the province are applied (Continuing Care Act, 2000, p. 1).

Health status is determined through assessment of functional capacity (i.e., capacity for functional independence) based on measures of basic activities of daily living (ADL), instrumental activities of daily living (IADL) and cognitive ability. Functional ability with regard to basic activities of daily living measures health status with regard to the ability of an individual to eat, dress, move around the house, get in and out of bed, and engage in toileting and bathing. Functional ability with regard to instrumental activities of daily living is assessed in terms of the ability to walk a city block, do laundry, shop, do heavy housework, do light housework and engage in yard work and gardening. In essence, this is a measure of the ability of the individual to function within his/her home without assistance on a day-to-day basis. The MMSE or mini mental state exam is a measure of cognitive ability. The Folstein Mini-Mental State

Exam gives a brief assessment of a person's orientation to time and place; recall ability, short-term memory and arithmetic memory.

Currently, fees are calculated based on revenue declared through income taxes. A single person attempting to access fully subsidized home care service must declare less than $10, 284 gross income per annum; for a dual income household, the cut-off is $16,752 per annum. Should household income exceed these amounts, a client is charged a daily rate calculated based on remaining income multiplied by 0.0013889 (Continuing Care Act, 2000, p. 2). The maximum number of care hours available for an extended care client is approximately 120 hours a month or 30 hours a week (British Columbia Ministry of Health, 2000, p. 5). Home support services beyond what may be covered by the province, either in terms of eligibility or care needs which exceed the maximum care hours, may be purchased privately at a cost of around 26$ per hour (Continuing Care in British Columbia Fact Sheet, 2000).

The assessment process itself has been criticized on several points. A single entry system may limit options and discriminate among those with non-acute care needs. The drive to eliminate duplication and increase efficiency has led to a reduction of service options. "As single access gatekeepers, they effectively hold a monopoly over publicly subsidized services, so that old people voicing needs outside the dominant discourse (the medical model) would have little choice but to accept their limitations" (Aronson, 1992, p. 83). While in theory older adults whose needs are not being met through the public system could access private service, this presupposes both economic privilege and social resources to assist in the search for appropriate assistance as well as the availability of private service providers.

Finally, it has been asserted that the implementation of needs assessments and income testing requirements in B.C.'s Continuing Care Act effectively accomplishes the task of cost effectiveness through exclusion. "By limiting public services to those with high needs and lowest incomes, the burden of care is shifted to informal caregivers" (Chappell and Penning, 2001, p. 92). Following a political economy approach, this may be seen as representative of a larger neo-liberal ideology, which devalues unpaid caring labour – labour generally provided to and by women – and symptomatic of the modern welfare state's desire to shift the burden of care from public to private (Armstrong, 2001;

Williams et al., 2001). Thus, by limiting the availability of services, the private sector becomes responsible for the care needs of many seniors, whether or not the care they are able to provide may be desired or appropriate.

3.6 Inequalities in Health-Related Care Needs and In-Home Care Usage

Prior research has revealed differences in both health and home care usage along both gender and economic lines. For example, several studies have reported that women are more prone to suffer from chronic illness (Millar, 1995; Hubert et al., 1993; Statistics Canada, 1994; Wilkins and Park, 1996), are more likely to live in poverty (Brotman, 1998; McDonald, 1997; Norris et al., 1999; Myles, 2000), are less likely to have informal social supports available to provide them with intense levels of care (Barrett and Lynch, 1999; McDaniel and McKinnon, 1993; Rosenthal and Gladstone, 1993) and have a higher probability of accessing formal care services than men (Chen and Wilkins, 1998; Chipperfield, 1994; Crowell et al., 1996; Hall and Coyote, 2001; Mutchler and Bullers, 1994; Wilkins and Park, 1998). Yet they also experience greater longevity (Statistics Canada, 1991; Millar, 1995).

For both men and women, the need for care or assistance stemming from chronic illness is also known to be higher for those with lower socioeconomic status and among those in the working classes (Arber and Ginn, 1991; Cairney and Arnold, 1996; Norris, 1999; Navarro, 2002). This persists into old age: "Social class differentials in physical morbidity clearly exist after age 65 in Canada" (Cairney and Arnold, 1996, p. 202). Despite the apparent need for in-home care services associated with physical decline among those of lower class status, both men and women with lower levels of educational attainment have been found to be less likely than those with higher levels of education to access formal care services given the same level of health-related need (Chen and Wilkins, 1998; Denton, 1997). "This suggests the possibility that for seniors with little education, lack of knowledge of the availability of formal services, or assumed costs, may have been a barrier to access" (Chen and Wilkins, 1998, p. 46).

Despite the fact that those with lower levels of educational attainment are less likely to access care services, those with lower incomes are more likely to experience

higher care needs and consequently, are also more likely to access formal care services in order to meet their care needs (Chen and Wilkins, 1998; Kemper, 1992). However, Wilkins and Park (1998, p. 35) found that although those with lower income accessed a greater proportion of home care services, this could not simply be attributed to poorer health experienced by those in lower socioeconomic groups. "After controlling for health status, smoking and the presence of chronic conditions, the odds of receiving home care were 1.6 times as high among people in the two lower income groups as among those in the three higher income groups". The authors posit that this may be attributed to some factor not measured by the income variable or that those with greater income may be more prone to access private service, or have greater levels of social support and access to informal care networks.

Canadian studies have neglected to directly examine the connection between class and gender in relation to both care needs and access to care services. In spite of the fact that it is well-established that socioeconomic and class status are important determinants of health and service use (Arber and Ginn, 1991; Cairney and Arnold, 1996; Humphries and Doorslaer, 2000; Mustard et al, 1997), and that women are at greater 'risk' of needing care (as outlined above), the link between class and gender in relation to home care use remains relatively unexamined.

While it has been well-established in the literature that socio-economic status is linked to poor health (Humphries and Doorslaer, 2000; Mustard et al., 1997), these findings and the speculation surrounding them clearly reveal how little we know about the impact of income requirements in accessing publicly-funded care and how this impacts men and women differently. While the authors speculate that those in higher income brackets may be able to pay for care, there is little discussion about how policy may impact those of varying class positions in accessing it. No doubt this is in part because there has been little to no research done on the effects of income testing in Canada on access to home care or home support services despite the fact that several provincial governments including New Brunswick, British Columbia and Alberta have adopted such a system (Norris et al., 1999).

Further, despite the fact that the provision of formal in-home care services may delay or prevent costly institutionalization and allow older adults to retain their

independence and improve or maintain their quality of life, past research in Canada indicates that only about half of seniors who require personal assistance have their care needs fully met (Chen and Wilkins, 1998; Wilkins and Park, 1998). For those with needs for assistance in such areas as preparing meals, shopping and doing housework, the percentages not receiving home care are even greater (Wilkins and Park, 1998). Indeed, results from analysis of the 1991 Health and Activity Limitation Survey by Statistics Canada indicate that the prevalence of unmet needs is greater for those with low incomes, low levels of educational attainment, more advanced age, and with fewer social supports (Chen and Wilkins, 1998).

The differences in access to care were especially high among women. Chen and Wilkins (1998) found that "The age adjusted prevalence of unmet need was 23% among women in lower income households, compared to 13% among women in higher income households.... By contrast, for men, the prevalence of unmet need varied little by socioeconomic status and was lower than that for women in each category, indicating that senior mens' needs were better met" (Chen and Wilkins, 1998, p. 45).

In British Columbia, Vogel (2001) reports that among those who applied for government-funded home support services in B.C., the vast majority had incomes that were below what Statistics Canada defines as middle or lower-middle class for a major metropolitan city[8]. "Among single seniors who needed subsidies in 1998-99, fully 82.2 percent of all home support applicants had annual incomes of below $20,000" (Vogel, 2001, p. 37). This finding may reveal that those with lower incomes are more vulnerable to illness, may be more socially isolated and consequently need formal instrumental assistance.

Thus, despite considerable knowledge about the demographic characteristics of those who access formal care services, we know comparatively little about the appropriateness of the care provided in relation to the mandate of the Continuing Care Act. Further, there has been a lack of research exploring relationships involving reductions in funding, the implementation of in-home care policy and programming and social inequality among older adults, women and those of varying class position.

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[8] As defined by Wilkins and Park (1998) for Statistics Canada.

A political economy perspective suggests that the modern welfare state acts to preserve the interests of the capitalist economy. The state is not neutral with respect to class but rather, is seen as maintaining or creating class inequality. Nor is the state neutral when it comes to gender or age. Recent formulations suggest that its focus is on meeting the needs of the economy and paid labour. These arguments suggest that the state systematically disadvantages those in lower classes, women and older adults, thereby sustaining existing inequalities.

The means by which this is accomplished is through the development and implementation of policies (including health care policies such as in-home care) that attempt to shift the onus of care from public to private, and limiting access to public services (such as home care) to an increasingly smaller and more select group.

Thus, in applying a political economy approach as a guide in examining accessibility to in-home care, we are lead to examine in-home care policy as articulated through the welfare state. It is argued that accessibility to in-home care services will be affected by how the welfare state determines and implements eligibility criteria. Further, according to a political economy approach, both income-related benefits as well as means tested social welfare programs are a reflection of power relations, and may contribute to sustaining inequity among older adults.

3.7 Statement of Research Objectives

A review of the literature suggests that support services in British Columbia are increasingly targeted to those requiring higher levels of care. By limiting access to a select group, and increasing emphasis on medical interventions such as nursing and therapeutic services, the responsibility of care is shifted from the public to the private sector. As fewer older adults are eligible to receive services, those who are unable to afford private formal care services to meet their needs may be forced to rely on informal social networks to provide them with care.

Although informal social networks may be a solution for some older adults, there are concerns that many individuals with lower class or economic standing will suffer consequences associated with limited financial resources including greater care needs

associated with long-term chronic illness as well as smaller informal support networks. As this population is at greater risk of experiencing illnesses that require constant and sometimes intense care, informal care may be inappropriate, unavailable or unreasonable for both caregivers and the recipients of care. Further, it seems likely that these developments will particularly impact upon older women. As noted, older women are known to be at greater risk of experiencing poverty, long-term chronic illness, and have less access to informal social networks able to provide them with care than men.

These findings suggest that despite claims that it is those who are most in need that are given access to publicly subsidized care, definitions of health-need which adopt a medical model of health, and assumptions surrounding the role of informal social networks may discriminate against rather than assist the very groups most in need of assistance. Guided by a political economy approach to aging, the purpose of this research is to examine public policy in relation to inequalities among older adults in accessing[9] in-home care services, with particular attention given to class and gender.

In order to explore if there are class and gender differences in health-related need and access to care, as well as to determine if informal social networks and the type of health-need influence type and extent of care received, the following questions have been examined:

1. What impact do gender and class have on health-related need as defined by health policy?

2. What impact do gender and class have on the type as well as the extent of in-home care received?

3. What impact do gender and class have on the relationship between health needs as defined by policy and the type and extent of in-home care received?

4. What impact do informal social networks have on relationships involving gender, class, health-related need and the type and extent of care received?

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[9] Access in this case refers to availability of service given a similar level of health related need across gender and income levels. Although it is impossible to tell if the service itself was offered to respondents (or voluntarily refused), we can infer, given a similar level of health need and income, that accessibility to service is inequitable (for a number of reasons – including the types or appropriateness of services offered) should there be significant differences in utilization rates among certain groups (i.e. women, the poor etc).

5. What impact do gender, class, health-related need and informal social networks have on access to publicly financed care?

A review of the literature suggests a need to determine if gender and class influence health needs as defined by the provincial assessment tool (LTC1), if types of health related needs (ADL or IADL) influence the type and extent of care received as well as revealing how health-related need, class and gender interact to influence the availability, type and extent of care received. Further to this, although there are conflicting policy statements surrounding the importance of informal networks in the determination of care needs in the assessment process, the impact of informal social networks (both type of relationship and social network size) would appear important to consider given the increased emphasis on the private sector to provide care.

Although a political economy perspective on aging is often associated with historical analyses, the focus of this research is located within a specific time and context. Thus, it may be said that a political economy approach guides this study as a critical theory, but it does not address systemic patterns of inequality articulated through the development of public policy relating to in home care, nor does it examine British Columbia's Continuing Care policy in relation to historical changes or over many years. Instead, a political economy of aging approach is used as a theoretical framework to guide our understanding of the social world and inform the type of questions and analyses conducted.

Chapter 4: Methodology

4.1 Data Source

The data used in this study were collected as part of the Patterns of Care Project (Penning et al., 1996) carried out from 1995-1998 on the importance of self, informal and formal care services to the frail elderly in retaining their independence through assistance with tasks of daily living. These data were chosen for this study because of the broad range of questions asked of respondents in regards to their health, occupational class, income, range of social supports and use of in-home care services specific to the Capital Regional Health District in British Columbia. As well, unlike most other data collected on the use of home care and home support services, this survey included not only those who received fully subsidized in-home care services, but also those who paid for private in-home care and support services, potentially capturing class differences in the type and extent of care services accessed by older adults in B.C.

What makes this survey unique also limits its generalizability as the survey is not considered representative of the general population of older adults, but more closely represents those who use in-home care services and those who are characterized by a high level of need. As such, any conclusions drawn may not be applicable to older adults as a whole or even to those in different regions of the country given differences in eligibility criteria and home care program structures among the provinces.

The initial sample consisted of 1,012 older adults-506 users and 506 non-users of publicly funded home support services. Structured survey-type interviews were conducted with a randomly selected sample of users aged 65 and over of publicly-funded home support services and a matched sample (by age, gender, and functional health status) of non-users of these services. All respondents in the study lived in the community as opposed to institutional settings and resided in the Capital Regional Health District in the province of British Columbia. Data were gathered through face-to-face interviews at two points in time, in 1995-96 and approximately one year later in 1996-97. This study uses baseline data collected in 1995-1996.

The original sample of service users was randomly drawn from a list of all those receiving publicly subsidized home support services as of May 1995. Of the 962 persons

contacted, 333 (34.6%) were unable to be interviewed because of illness or because they had moved to long term care, were deceased, were not able to be contacted, did not speak English or were no longer receiving home support services. The refusal rate for this group was 8.7 percent.

Non-users were initially identified on the basis of telephone screening interviews conducted with a random sample of older adults (aged 65 or older) from the region and drawn from a listing obtained from the department of Vital Statistics (N=56,774). Over 10,000 telephone screening interviews were conducted which asked respondents their date of birth, gender, whether they used services in the Capital Regional District and a series of questions surrounding basic and instrumental activities of daily living as a measure of functional ability. Non-service users were then matched as closely as possible to service users in the sample by sex, age and functional ability. For practical reasons, functional ability as measured through activities of daily living were summed and categorized into two groups: 1) those who reported no ADL limitations and 2) those who reported any degree of ADL impairment. Those who reported no functional impairment with activities of daily living were matched based on ability to perform instrumental activities of daily living. However, this group made up a very small proportion of the overall sample (N=68). In total, 810 non-users were contacted to participate in the study, of whom 166 were unable to be interviewed because they had moved into long term care settings, began receiving home care services, etc. The refusal rate for this group was 21.5 percent. The overall refusal rate was very low (13.4%).

It should be noted that the study began following a period of service reductions that saw a review of all clients receiving weekly housekeeping services and the termination of home support services to 72% or 1,932 of the 2,674 clients reviewed (Chappell and Penning, 1996, p. 9). Those who had services terminated were not included in the survey. The implication of the service reductions is that those who were characterized as having lower levels of functional impairment were excluded from study, and were consequently unable to comment on the effectiveness or appropriateness of the services offered in maintaining their independence.

4.2 Measurement

Tables 1 and 2 report the means, standard deviations and coding used for all variables in this study.

4.2a Dependent Variables

Health Related Care Needs – As noted in the review of the literature, the province of British Columbia uses an assessment instrument, the LTC1 (see Appendix A), to measure 'need' for services. A copy of that assessment tool has been obtained, and a measure of health-related care needs developed based on the criteria outlined within it in order to, as clearly as possible, approximate the conceptual and operational definition of health-related need outlined in public policy. Like other assessment tools, this instrument assesses health related care using measures of ability with regard to basic activities of daily living (ADL) and instrumental activities of daily living (IADL) as well as a measure of cognitive ability termed the Folstein Mini Mental State Exam (MMSE). Both ADL and IADL impairment are widely acknowledged as accurate measures of functional health status and important determinants of access to formal care services (Chen and Wilkins, 1998; Crowell et al., 1996; Hall and Coyote, 2001; Wilkins and Park, 1998). Although the MMSE cannot be used to diagnose dementia, it may be used as a screening tool for cognitive loss and cognitive assessment, and is generally considered to be a reliable measure of basic cognitive ability (McDowell and Newell, 1996).

Functional ability assessed in terms of basic activities of daily living measures health status with regard to the ability of an individual to perform activities such as being able to eat, dress, move around the house, get in and out of bed, and engage in toileting and bathing. Functional ability with regard to instrumental activities of daily living is assessed in terms of the ability to perform activities such as walk a city block, do laundry, shop, do heavy housework, do light housework and engage in yard work and gardening. In essence, this is a measure of the ability of the individual to function within his/her home without assistance on a day-to-day basis.

While measures of ADL and IADL functioning may be characterized as measuring health status, they do measure different aspects of physical functioning (McDowell and Newell, 1996). ADL skills include activities that generally involve personal care. Developed by Katz (1963), the ADL scale was designed to measure the physical functioning of elderly and chronically ill patients. Katz noted that the loss of functional skills occurs in a particular order with the most complex functions being lost first. He also suggested that during rehabilitation, skills are regained in an ascending order of complexity (McDowell and Newell, 1996). According to Katz, the index of ADL appears to reflect primary biological and physiological functioning. Although commonly used in both clinical and social sciences research, the ADL index only captures relatively severe levels of disability. "Minor illness or disability frequently does not translate into the limitations of activities of daily living covered in this scale" (McDowell and Newell, 1996). Thus although the ADL index is a useful tool in determining levels of severe illness, it has been suggested that the ADL instrument alone is not appropriate in determining eligibility for in-home care as it does not reflect the ability of the respondent to perform more complex activities needed to remain independent in the home (Hollander et al., 1996).

IADL measures represent a range of activities related to self-care that involve a greater complexity than those needed for personal care which are included in ADL measures (Hollander et al., 1996). As noted, the IADL measure is considered an important measure in determining the suitability of in-home care. As Hollander (1996) notes: "quite naturally, an IADL scale is generally more appropriate in a home care setting or when determining the possible need for institutionalization, since those already residing in a facility will not normally report that they shop independently, prepare their own meals or even administer their own medications" (p. 22). Thus, IADL as a measure of functional ability, is distinct in that it captures level of ability in relation to the more complex functions needed to remain in the home and is an important determinant of placement and service considerations (Hollander, 1996). In combination with one another, ADL and IADL measures should provide an effective assessment of functional ability in an in-home care setting.

In this study, respondents' levels of functional ability with regard to both basic and instrumental activities of daily living were measured by asking respondents about their ability to perform various tasks. Responses to each question were coded using a 4-point scale ranging from '1' if the respondent required no assistance in performing the task to '4' indicating that the individual was unable to perform the task even with some assistance.

Ability with regard to basic ADL (Activities of Daily Living) was calculated by adding scores obtained for the ability of respondents to eat, dress, move around the house, get in and out of bed, and engage in toileting and bathing. The higher the score, the lower the level of functional ability. The range for this variable was from 5 to 31 with a mean of 10.53. When descriptive statistics were run, this variable was found to be skewed (skewness 1.82, standard error .077). In order to correct this skewness, this variable was logged. This variable was found to have a high degree of reliability (alpha=.84).

Functional ability with regard to Instrumental Activities of Daily Living (IADL) was calculated by adding the scores obtained for the ability of respondents to walk a city block, do laundry, shop, do heavy housework, do light housework and engage in yard work and gardening. IADL ability is interpreted in the same way as the ADL variable, with a high score indicating a high level of functional impairment and a low score indicating a low level of functional disability. This variable ranged from 6 to 30 with a mean score of 16.93, and was found to have a high level of reliability (alpha=.82).

The MMSE or Mini Mental State Exam is a widely used measure of cognitive ability. The Folstein Mini-Mental State Exam gives a brief assessment of a person's orientation to time and place, recall ability, short-term memory and arithmetic memory and was specifically designed for older adults where other tests may be deemed too lengthy. It is intended to be a screening test only (McDowell and Newell, 1996). The MMSE includes 11 items, divided into two sections. The first section requires verbal responses to orientation, memory and questions that test the respondent's attention span. The second section requires reading and writing skills and covers ability to name, follow verbal and written commands. Each question is assigned a point value with a maximum score possible of 30 (McDowell and Newell, 1996). Unlike the ADL and IADL

measures, in this case, a higher score indicates a higher level of cognitive ability. McDowell and Newell (1996) suggest that the cut point most often used to indicate cognitive impairment that deserves further investigation is a score of 23 or 24.

The range of scores obtained for this variable in this study was between 5 and 22 with a mean of 18.95, indicating that some respondents in the sample are experiencing some level of cognitive impairment. This variable was found to be negatively skewed (skewness=–1.35, standard error .077) which was corrected through the creation of a quadratic term (skewness=-.871, standard error =. 077). The reliability of this variable was found to be relatively low (alpha= .59). Thus, the decision was made to include this in the analyses with caution being given surrounding validity of results.

Type of Service Received – In order to determine if there are gender and class differences in the receipt of service as well as the type of services received, a categorical variable was created based on questions which asked respondents about the nature of the care they received (i.e., "Has anyone helped you with the task in the last month?"). Based on their responses, participants were placed into one of three mutually exclusive categories:

1) Do not receive any services (27.2%).
2) Receive home support services only (68.8%).
3) Receive both home nursing and home support services (4.1%).

Ideally, a fourth category would have been created which included those who received home nursing services only. However, when preliminary models were tested, it was found that only three respondents of the 1,012 who were interviewed received exclusively home nursing services, which subsequently made separate analyses impossible. A decision was made to include those respondents who received home nursing only with those who received both home nursing and home support services as it was felt that the inclusion of these three respondents would not significantly skew the final results.

Extent of Service Received – To measure the extent of care services received among those who received home support services only as well as those who received both home nursing and home support services, a variable was developed based on the number of care hours and the nature of assistance received. Respondents who received

assistance with various IADL and ADL activities were asked how often they received help (how many visits per month) and for what duration of time (in minutes per visit). Additionally, respondents were asked who provided them with assistance for the given activity. The extent of care received was then calculated by multiplying the number of visits by the average length of the visit and categorized as formal care when someone who was paid provided assistance with the said activity.

Ideally, two variables would have been created that measured the extent of care received by those who received home support services only, and a separate variable that examined the extent of services received among those who received both home nursing and home support services. However, the extremely small number of respondents who reported receiving both home nursing and home support (N=40) made any sort of meaningful regression analysis of extent of care services among this group impossible. Thus, one variable was created that measured total care hours among all respondents that reported receiving in-home care services.

The range of care for all respondents extended between 25 minutes and 633 hours per month with a mean of 44.35 hours per month. Although the province of British Columbia limits the number of care hours available to 30 hours per week or 120 hours per month (in exceptional circumstances a case manager may request more care hours with approval from a supervisor) (British Columbia Fact Sheet, 2000), this sample includes both publicly administered care as well as privately accessed care services. As is reflected in the extent of home support services received, a significant number of older adults in this sample may have gone to the private sector to meet their care needs. When descriptive statistics were run for this variable, a positive skew was evident (skewness=7.89). In order to correct for this, this variable was logged prior to analysis.

Portion of Payment – As noted earlier, one of the unique features of these data are that they include not only publicly subsidized service use but also, services which are privately accessed. This allows for a thorough examination of class differences in how care services are accessed. To determine whether home support services were publicly subsidized or privately paid for respondents were asked: "Do you or your family pay for some, all or none of the services provided". It should be noted that home nursing care services were not included, as those services are not subject to income testing under

B.C.'s Continuing Care Act. Those respondents who did not receive any services were not included in analyses with portion of payment as the dependent variable (N=729). The variable was created using three categories:

1) Receive service but do not pay for any costs (43.3%);

2) Receive service and pay for a portion of that service (20%);

4) Receive services and pay for all costs (36.6%).

Table 1. Coding, Means, Distributions and Standard Deviations of Dependent Variables

	Mean/ Distribution	SD
Health Related Care Needs:		
ADL Impairment	2.31	0.28
(Logged Range 1.61 to 3.43)		
IADL Impairment	16.93	6.39
(Range 6 to 30)		
Cognitive Impairment	386.48	102.78
(Range of Quadratic term 25 to 484)		
Type of Care Received:		
1) Did not Receive any Service	27.2%	
2) Received Home Support Services Only	68.8%	
3) Received Home Nursing and Home Support Services	4.1%	
Extent of Care Received:		
Total Care Hours		
(Logged range 3.22 to 10.43)	6.50	1.06
Portion of Payment:		
1=Pay for None	43.3%	
2=Pay for Some	20.0%	
3=Pay for All	36.6%	

4.2b Independent Variables

Gender – Gender is given primacy in all analyses and is included as an independent variable. Not surprisingly, given women's greater longevity, women make up the largest proportion of respondents (81%).

Class – To measure social class, the Pineo-Porter-McRoberts (1981) Socioeconomic Classification Scale of Occupations was applied. Although there are a number of occupation-based class measures that have been proven to be effective instruments, the Pineo-Porter-McRoberts scale is most often applied by Statistics Canada and has been specifically created to measure occupational class in the Canadian Context (Brighton and Connidis, 1984; Cairney and Arnold, 1996; Deonandan et al., 2000; Marshall, 1999).

Recently, Deonondan et al (2000) tested different measures of occupational class including the Blishen, Pineo-Porter, Hollingshead and British indexes of occupations. Their findings indicated that the Pineo-Porter index of occupations for Canada was as reliable a measure of occupational class as the British Registrar General's Index of Occupations, and best integrated income and education into the occupational measure. Prior research has shown that the British Registrar General's index of occupations is an accurate predictor of occupational class[10] (Arber and Ginn, 1991; Arber and Evandrou, 1988; Cairney and Arnold, 1996; Glaser and Grundy, 2000; Krieger and Fee, 1994; Krieger, Williams and Moss, 1997; Manor et al., 1997; Wood et al., 1999).

The Patterns of Care Survey asked respondents "What was your major occupation in life?". The open-ended responses were then coded into the relevant four digit occupational codes from the Canadian Classification and Dictionary of Occupations (C.C.D.O.). These codes were recoded using the Pineo-Porter-McRoberts (1981) classification scheme, and then further collapsed into six separate categories intended to provide the best available approximation to the Registrar General's Classification of Occupations, which is used extensively in studies of social class and health (Cairny and Arnold, 1996; Krieger, Williams and Moss, 1997; Wood et al., 1999). The category of homemaker was also included to allow for an examination of the substantial proportion

[10] Although it should be recognized that there is no consensus on what constitutes the best measure for occupational class

of women who would otherwise be excluded from the study. Indeed, homemakers have not been included in the C.C.D.O., the Pineo-Porter-McRoberts Scale or any other measure of occupational class. However, given the prominence of women who reported they worked in the home, and the absence of a partner's occupational status, a separate category has been created in order to include them in subsequent analyses. The categories created were as follows:

(1) Professionals and High-Level Managers (9.8%);

(2) Managers and Technicians (17.7%) which included self-employed professionals, middle managers, semi-professionals and technicians;

(3) Skilled Labourers (15.7%) including foremen and women, skilled clerical sales and service, skilled crafts and trades people and supervisors;

(4) Semi-Skilled Labourers (16.7%) includes semi-skilled clerical sales and service and semi-skilled manual labourers;

(5) Unskilled labourers (4.3%) including farm labourers and unskilled labourers;

(6) Homemakers/never worked (35.8%).

Socioeconomic position - The strategy usually employed by sociologists interested in obtaining a measure of class within an aging population is to use the previous occupation of the respondent (Adler et al., 1994; Duncan et al., 2002; Kazanjian et al., 2001; Krieger and Fee, 1994; Manor et al., 1997; Winkleby et al., 1992; Wood et al., 1999). Indeed, this tactic is employed in this study as outlined above. However, although occupation is a commonly used measure of class status, recent research within the health and aging literature suggests that occupation among both women and an older cohort may be an ineffective measure (Adler et al., 1994; Duncan, 2002; House et al., 1994; Robert and House, 1996).

This may be for a number of reasons. To begin with, it assumes that the respondent has been previously employed in the formal economy. For older men, it is relatively simple to use their last occupation as an indicator of their current class status. However, many older women have never worked outside of the home, or had worked outside of the home early on in the life course, exiting the formal economy when they married or had children. Indeed, over one-third of all respondents in this study reported

being homemakers. One commonly used approach to this dilemma has been to assign the class status of the husband to the woman in question. However, this approach then assumes that the husband's class status and his previous labour market position influence the current life chances, attitudes and social relationships of all household members over an indefinite period of time (Arber and Ginn, 1991). While this may be the case, it has not been adequately tested empirically and consequently, may be an inaccurate assumption (Krieger, Williams and Moss, 1997).

Further to this, applying occupation as a measure of class to an older cohort may in itself be problematic. Social mobility has been primarily studied from an intergenerational point of view and stratification theorists have often neglected issues of lifetime change in material resources (Arber and Ginn, 1991; Krieger, Williams and Moss, 1997; Myles, 1980). Changes in income and other dimensions of inequality (including ageism) over the entire life span need consideration. "It is important to understand the dynamics of social inequality, to recognise its temporal dimension, and to recognize that it is a process rather than an unchanging structure" (Arber and Ginn, 1991).

Given these arguments against using occupation as the sole measure of class status for an older cohort and women, and the pragmatic limitations of the data themselves (e.g., not having access to a spouse's occupation), socioeconomic position has also been included in all analyses in order to more fully capture class-based differences in health, resources and status.

Duncan et al. (2002) recently examined the sensitivity of empirical measures of SES indicators for mortality risk. They concluded that economic measures, including income and family wealth (such as property ownership and assets) were more effective predictors of mortality risk than more traditional measures of SES such as occupation and education. These findings were especially salient when measuring the link between mortality risk and SES among women - as women typically receive less return on educational investment and may not have previously worked outside of the home (Adler et al., 1994; House et al., 1994; Krieger and Fee, 1994; Robert and House, 1996).

Based on these findings, socioeconomic position in this study has been measured through gross household income, property ownership and the presence or absence of

savings or investments (as a measure of wealth). Additionally, although Duncan et al. (2002) found that education was a poor measure of mortality risk as compared to economic indicators, education is also included in the analyses. Prior research has linked educational attainment with positive self-care behaviours (Konrad, 1998; Krause, 1996), lower incidence of morbidity and mortality (Freund and McGuire, 1995; Humphries and Doorslaer, 2000; Mustard et al., 1997), and formal service use (Coyote and Young, 1999; Crowell et al., 1996; Hall and Coyote, 2001; Rosenberg, 2000). Further, education also encompasses shared values and common interests, which may give a better approximation as an alternative measure of class among an older cohort. Thus, socioeconomic position is based on current Statistics Canada definitions of income adequacy as well as educational achievement and the presence of assets and property ownership.

Income adequacy as defined and measured by Statistics Canada is based upon household income per year and the number of persons living in the household. The five categories for one to two persons are: 1) lowest - $10, 000 or less per year; 2) lower-middle - $10, 000 - $14, 999 per year; 3) middle - $15, 000- $29, 999 per year; 4) upper-middle - $30,000 – $59,999 per year and 5) highest - $60, 000 or more per year (Cairney and Arnold, 1996; Wilkins and Beaudet, 1998). This also appears to correspond with measures of poverty and income adequacy for the Capital Regional District in 1996 – the time the study occurred. According to the Income Statistics Division of Statistics Canada, the low-income line for those living in an urban area comprised of 100,000 to 499,999 people was $14,694 for one person and $15,085 for a two-person household.

Originally, the income variable was coded on a 24-point scale in response to the question "What is your average monthly household income?" with responses ranging from (1)"no income" to (24) monthly income of "$5,500 or more". Additionally, there were a large number of missing values (17.4%). In order to include all possible respondents in the analysis, the missing values were replaced with the means for both service-users (6.55) and non-users (8.19).

In order to approximate Income adequacy as measured and defined by Statistics Canada, five income categories were subsequently created:

1) Gross yearly income of $9,000 or less (6.7%)
2) Gross yearly income between $9,001 and $14,988 (41.4%)
3) Gross yearly income between $15,000 and $29,988 (41.2%)
4) Gross yearly income between $30,000 and $59,988 (7.8%)
5) Gross yearly income of $60,000 or greater (2.9%)

Given that the income adequacy levels set out by Statistics Canada are for a one to two person household, and 94.9% of all respondents in this study reported either living alone or living with one other person, it was decided that no further weighting for household size was required.

In addition to income, assets have been measured through the presence or absence of savings and interest earnings through investments (no savings or earnings (58.8%); presence of savings or earnings (40%)), and property ownership (rent from other (46.5%); own home (53.2%)). Education was measured in years on a continuous scale from 1 year of formal education to 24 (mean of 11.29 years). Although these measures are imperfect approximations of socioeconomic status, based on prior research, in combination with one another, they should provide a reasonable assessment of socioeconomic position.

Social Resources – In order to determine if the presence or absence and type of informal social networks influences the receipt of care and how this may vary by gender and class, several measures have been constructed based on the size and nature of the relationship to the respondent. The numbers of nuclear and extended family members, friends and neighbours have been calculated based on the respondent's answers to the questions "How many family members do you have?", "Other than relatives how many people do you consider close friends?" and, "How many of your neighbours do you know?".

Although many respondents reported having an extensive social network, there were a few respondents who reported extreme scores (i.e., 43 family members, 99 friends and knowing more than 96 of their neighbours). Therefore the scale for family members was truncated at 90% of responses, which translated into a maximum of 12 family

members. Similarly, the scales for friends and others were also truncated at 90% of responses, translating into a maximum of 15 friends and 15 others in order to avoid problems associated with skewed distributions. Truncating these scales allows for a more accurate estimation of the types and extent of informal networks, as extremely large social networks would undoubtedly affect the rest of the data. However, in truncating these results, some power and the ability to generalize to those with exceptionally large social networks is lost.

Once scores were truncated, the mean number of family members within this sample was 5.56 with a median of 5.0 (SD=3.02), with 45% of respondents reporting more than 5 family members. Many respondents reported having a significant number of friends with a mean value of 5.77 and a median of 6.0 (SD=5.60). Only 42% of respondents reported having more than 5 friends. Finally, respondents reported knowing a mean of 5.66 neighbours with a median value of 5 (SD=5.87). In this case, 67% of respondents knew more than 5 such persons.

Marital status is also considered an important predictor of the availability of social support and informal care and is known to be associated with the utilization of formal services. As such, it is also included in the analyses as part of the social network variables. Because living arrangements and marital status are so highly correlated, these two variables have been combined. Given the high proportion of respondents who reported being unmarried but living with at least one other person, marital status includes not only those who are married and live with a spouse or unmarried and live alone, but also those who are unmarried and live with others. The categories were created and distributed as follows, with those who reported being married used as the reference category:

1) Unmarried (widowed, divorced, never married) and living alone (24.5%);
2) Married and living with other (52.4%);
3) Unmarried (widowed, divorced, never married) and living with other (22.4%).

4.2c Control Variables

The control variable age is measured in years. The respondents ranged in age from 65 years to 102 years, with a mean of 82.43 years.

Table 2. Coding, Means, Distributions and Standard Deviation of Independent and Control Variables

		Mean/ Distribution	S. D.
Class:	***Pineo-Porter Index of Occupations***		
	1= Professionals	9.8%	
	2=Managers and Technicians	17.7%	
	3=Skilled Labourers	15.7%	
	4=Semi-Skilled Labourers	16.7%	
	5=Unskilled Labourers	4.3%	
	6=Homemakers/Never Worked	35.8%	
Socioeconomic Position:	***Income Categories – Gross Yearly Income***		
	1= $9,000 or less	6.7%	
	2= $9,001 to $14,988	41.4%	
	3= $15,000 to $29,988	41.2%	
	4= $30,000 to $59, 998	7.8%	
	5= $60,000 or greater	2.9%	
	Home Ownership		
	0= Rent from Other	46.5%	
	1= Own Home	53.2%	
	Assets		
	0= No assets	58.5%	
	1= Liquid Assets	40.0%	
Education:	***Education in years***	11.29	3.32
Gender:	0=Male		
	1=Female		
Informal Social Networks:	Number of Family Members	5.56	3.02
	Number of Friends	6.24	5.60
	Number of Neighbours	6.18	5.87
	Marital Status/Living Arrangements		
	1=Married and Live with Other	24.5%	
	2=Unmarried and Live Alone	52.4%	
	3=Unmarried and Live with Other	22.4%	
Age:	Measured in Years	82.43	7.18

4.3 Methods of Data Analysis

In order to address questions surrounding gender and class differences in health-related need and the type and extent of care received, a variety of analytical techniques were employed. Initially, the frequencies and distributions of all variables were examined to assess the basic characteristics of the data. Bivariate analyses were then conducted to assess relationships between the variables. Next, in order to address questions surrounding the impact of gender and class on health-related need and to determine the impact of gender and class on the extent of care received, ordinary least squares regression analysis was applied. Before beginning this analysis, assumptions surrounding ordinary least squares regression were examined in relation to the data used.

Regression analysis examines the relationship between a quantitative dependent variable and one or more quantitative independent variables (Fox, 1997). OLS (ordinary least squares) regression is concerned with finding a regression line that provides the best fit to the data points through minimizing the sum of squared residuals (also known as the sum of squared errors), which is the variation of the observed points around the prediction line (Agresti and Findlay, 1997). What this means is that OLS regression creates a linear model that produces the minimum average prediction error. This creates a regression line that best describes the data, allowing us to more accurately predict the relationship between the dependent variable and independent variables (Agresti and Findlay, 1997).

The OLS model makes several assumptions about the nature of the data used. The first assumption is that there are no influential data such as outliers, which may influence or pull the regression line, changing the intercept and slope (Agresti and Findlay, 1997). To determine whether any of the variables were not normally distributed (or skewed), all dependent and independent variables included within these analyses were tested for skewness and kurtosis. Three dependent variables were found to be positively skewed with a value above 1.5 (ADL disability and extent of care hours for both home nursing and home support services). These variables were transformed (logged) to correct this positive skew. Additionally, the test of cognitive ability (MMSE) was found to have a

negative skew, and was transformed through the use of a quadratic term. These transformations allow for a more accurate representation of the data (Fox, 1997).

The second assumption of the OLS model is that the error terms are normally distributed for each set of values of the independent variables (Menard, 2002). As noted above, the least squares regression line is most efficient when the sum of errors is minimal. Thus, the normality of independent and dependent variables was examined through the use of normal probability plots (Hair et al., 1998). The data were plotted against a theoretical normal distribution in such a way that the points should form an approximate straight line. Departures from this straight line indicate departures from normality. Normal probability plots were created for all continuous variables (shown in Appendix B). Although ADL impairment and extent of care show slight deviations from a normal distribution, once these variables had either been logged or transformed into categorical variables, relatively normal distributions are evident. It was felt that no further adjustments were required.

The assumption of homoscedasticity - that the conditional variance of the error term is constant across the regression line was also examined. Diagnosis was made through the use of residual plots, which plotted the residuals (studentized) for each independent variable against the predicted dependent values and compared them to the null plot (Hair et al., 1998). The results are shown in Appendix C. Heteroscedasticity did not appear to be a problem with these data.

Multicollinearity or collinearity occur when two or more independent variables are redundant with one another. When the regressors in a linear model are collinear, the least–squares coefficients are no longer unique. This substantially increases the sampling variances of the estimators and can effectively render them useless as estimators (Fox, 1997).

Two steps were taken to determine the extent of collinearity evident among any of the variables. As a first step, a correlation matrix of the independent variables was examined (shown in Appendix D). Perfect collinearity (values of –1.00 or +1.00) indicates a perfect linear relationship between variables, indicating redundancy if both variables were used. High levels of collinearity (correlation coefficients of .70 or greater), although not indicative of a perfect relationship, may indicate problematic redundancy

(Fox, 1997). Findings from the correlation matrix revealed that none of the independent variables were highly correlated with one another, with the highest value evident between measures of income and portion of payment for home support hours (r=.43).

The second step in determining if collinearity was a problem involved applying VIF (variance inflation factor) and tolerance levels diagnostics to the data. The variance inflation factor tells us the degree to which each independent variable is explained by other independent variables (Hair et al, 1998). The tolerance is the amount of variability of the selected independent variables not explained by the other independent variables. Tolerance values range from 0 to 1, with a value closer to 1 indicating independence. In this case, the lowest tolerance value was .60 indicating that all variables are independent of one another, although there may be some dependence among variables (shown in Appendix E). The VIF score was also used to determine if collinearity was a problem (see Appendix E). Hair et al. (1998) recommends a VIF value of no greater than 10. In this case, the largest value was 1.68 indicating that collinearity is not a problem.

To address questions of whether care was received and if so what type (no care received, home support services only or both home nursing and home support), multinomial logistic regression has been applied. One of the assumptions of the OLS method is that the dependent variable is continuous, unbounded and measured on an interval or ratio scale (Menard, 2002). However, often what is of interest to researchers has not been conceptualized in these terms. In the case of a polychotomous dependent variable, the numerical value is arbitrary and does not represent a meaningful value. As Menard (2002:12) puts it: "What is intrinsically interesting is whether the classification of cases into one or the other of the categories of the dependent variable can be predicted by the independent variable". Thus, with a dependent variable that is made up of two or more categories, ordinary least squares regression is not an effective analytical tool.

There are a number of options available to deal with polytonomous responses. One option is ordered logistic regression. However, ordered logit presumes "...an intrinsic order or natural space among the response categories" (Futing-Liao, 1994, p. 48). In the case of the categorical variable in question – type of care received – we cannot assume an intrinsic order or sequence among the three categories. Indeed, there may be a great deal of variation in the distance among these three categories. Those who

do not receive any care may be further away from those who receive home support only, while there may be less distance between those who receive home support services only and those who receive both home nursing and home support services. Liao (1994) recommends that when unsure about whether the responses are ordered or sequential, multinomial logistic regression should be used. The rationale for this is that the multinomial logistic regression model uses fewer assumptions – leaving less room for the violation of regression assumptions and fewer errors.

Chapter 5: Findings

The central concern of this study is to investigate class and gender differences in health-related need and access to in-home care as well as to determine if social networks and the type of health need influence the type and extent of care services received and if this care is publicly funded or privately paid for. The results of bivariate, multivariate and multinomial regression analyses conducted to examine these questions are reported below.

5.1 The Impact of Gender and Class on Health-Related Need

The first question addressed within the study asked what impact gender and class have on health-related need. Following provincial policy, health-related need was measured based on measures of ADL (basic activities of daily living), IADL (instrumental activities of daily living), as well as cognitive (MMSE) ability and functioning. To examine this question, functional ability with regard to basic activities of daily living (ADL) was first regressed on control variables including age, marital status and living arrangements. Gender was then added to the model and finally class was added to complete the model. The same procedure was followed for socioeconomic position, in order to ensure that all measures of class were accounted for. This process was repeated for instrumental activities of daily living and cognitive ability. The results reported in Tables 3 through 5 include three models for each regression analysis. The first model represents the results from the regression analyses including control variables only. Although gender was initially entered without the class variable, there were no changes in levels of significance when the class measure was added to the models, thus the second model presented includes both gender and class. The third model presented for all three analyses includes measures of socioeconomic position as well as gender and the control variables in order to provide a fuller understanding of socioeconomic aspects of health.

As reflected in Table 3, when the control variables of age and marital status/living arrangements were initially tested in relation to ADL functioning, only being unmarried and living with others was found to be significant, indicating that age alone may not be an accurate predictor of this type of disability. Although those who are unmarried are

often identified as being at risk of experiencing lower levels of ADL functioning, in this case, we see that it is a specific group of those who are unmarried, namely those who live with someone other than their spouse who are more likely to experience care needs associated with the ADL measure.

When gender and class were entered into the equation, class was not found to be a significant predictor of health-related need as expressed through ability to carry out basic activities of daily living. Gender, however, was found to be highly significant in this model ($p<.000$), indicating that older women were more likely to experience functional limitations associated with basic activities of daily living than were older men. When socioeconomic position was entered into the analysis, none of the variables was found to be significant while gender remained significant at the .01 level[11]. The amount of variance explained by these models remained quite low throughout the stages of analysis. Only one percent (in model one when only control variables were tested) to a three percent (in model three which examined gender, control and socioeconomic position in relation to ADL functioning) of the total variance was explained by these models. However, the F statistics were found to be significant for all three models, and particularly significant ($p<.000$) for model three, indicating an overall linear relationship between ADL functioning and age, marital status/living arrangements, gender, class and socioeconomic position.

[11] The income variable was also tested in a model that did not replace missing values with their means. Instead, a separate category was created. There was no change in the level of significance among the income categories, nor the overall model.

Table 3. Impact of Controls, Gender, Class and Socioeconomic Position on Health Related Need: Basic Activities of Daily Living

	Model 1		Model 2		Model 3	
	b	**SE**	**b**	**SE**	**b**	**SE**
Age	0.00	0.00	0.00	0.00	0.00	0.00
Unmarried/alone	0.01	0.00	-0.00	0.02	-0.02	0.02
Unmarried/others	0.08	0.03***	0.06	0.03**	0.04	0.03
Gender			0.08	0.03***	0.06	0.02**
Professionals			-0.04	0.03		
Skilled labour			0.02	0.03		
Semi-skilled labour			0.03	0.03		
Unskilled labour			0.03	0.05		
Homemakers			0.01	0.26		
Income category 1					0.02	0.06
Income category 3					0.02	0.06
Income category 4					0.01	0.05
Income category 5					0.03	0.06
Education					-0.00	0.00
Home ownership					-0.03	0.02
Assets					0.02	0.02
Alpha	2.22	.10***	2.16	2.11***	2.21	2.12***
R2		0.01		0.03		0.03
F		4.24*		3.23**		2.76**

*p<.05; **p. <.01; ***p<.001

Table 4 presents the results for analysis of the impact of the control variables, gender, class and socioeconomic position on instrumental activities of daily living as a measure of functioning. Interestingly, in the first model tested, we find that age is among the control variables that emerge as a significant predictor of IADL functioning (at the .05 level), with disability increasing as age increases. Much like the previous analyses, those who were unmarried and who lived with someone other than their spouse are also more likely than others to experience greater levels of disability with regard to the tasks associated with instrumental activities of daily living. However, once again, we also find that although the F test indicates a strong linear relationship between the control variables and IADL functioning, only 1% of the total variance is explained.

The second model incorporates gender and class into the equation. In this case, neither gender nor occupational class is a significant predictor of functional decline surrounding instrumental activities of daily living, while there is only a slight improvement in the variance explained (2%). Model 3 incorporated socioeconomic position[12]. Interestingly, with these variables included, we find that age is no longer a significant predictor of functional ability. However, education ($p < .05$) is found to be significant, with those with less education experiencing higher levels of limitations with instrumental activities of daily living. Marital status/living arrangements was also found to be significant at the .05 level, with those who were unmarried and living with others being more likely to experience functional disability associated with instrumental activities of daily living.

It is important to note that although these variables are significant, very little of the overall variance is explained by these measures. However, once again, the F statistics indicate that there are significant linear relationships between the independent, control and dependent variables in all three models, with the strongest relationships found between socioeconomic resources, gender, age and marital status and instrumental activities of daily living ($F = 4.17$, $p < .000$).

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[12] The income variable was also tested in a model that did not replace missing values with their means. Instead, a separate category was created. There was no change in the level of significance among the income categories, nor the overall model.

Table 4. Impact of Controls, Gender, Class and Socioeconomic Position on Health Related Need: Instrumental Activities of Daily Living

	Model 1		Model 2		Model 3	
	b	**SE**	**b**	**SE**	**b**	**SE**
Age	0.07	0.03*	0.06	0.03*	0.06	0.03
Unmarried/alone	-.29	0.55	-0.21	0.52	-1.28	0.64
Unmarried/others	1.52	0.65*	1.36	0.59*	0.59	0.71*
Gender			0.74	0.58	0.15	0.62
Professionals			-1.27	0.80		
Skilled labour			-.202	0.69		
Semi-skilled labour			.680	0.68		
Unskilled labour			1.14	1.08		
Homemakers						
Income category 1					2.15	1.65
Income category 3					2.41	1.45
Income category 4					1.41	1.41
Income category 5					-0.59	1.55
Education					-0.14	0.07*
Home ownership					-0.50	0.48
Assets					-0.10	0.46
Alpha	12.63	2.63***	11.16	2.45***	14.16	3.20***
R2		0.01		0.02		0.04
F		4.50**		2.55**		3.32***

*p<.05; **p. <.01; ***p<.001

The findings for relationships between cognitive ability, age, marital status/living arrangements, class and socioeconomic position are presented in Table 5[13]. In model 1, the age variable is found to be negatively related to a high MMSE score at the .001 level, indicating that older participants are more likely to have lower MMSE scores indicating lower levels of cognitive ability (i.e. higher levels of cognitive impairment).

Model 2 presents the results for the control variables, gender and occupational class in relation to cognitive ability. Age was found to be the strongest predictor of cognitive ability ($p < .01$). Model 3 incorporated socioeconomic position into the equation[14]. Findings indicate that once again age ($p < .01$) was significant. Class ($p < .05$) was only a significant predictor of cognitive ability among professionals. In addition to this, education was also correlated with cognitive ability ($p < .001$), with those with higher levels of education experiencing less cognitive disability. Further, income was found to be a significant predictor of cognitive ability. Findings indicate that as income increase, cognitive disability significantly decreases. Only 6% of total variance was explained when class was entered into the model, and 13% when socioeconomic position was considered.

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[13] All three models were tested with the dependant variable (MMSE) as an untransformed variable. Findings indicate that there were no changes in the R2 value (model 1, R2=0.05; model 2, R2=0.06 and model 3, R2=13).

[14] The income variable was also tested in a model that did not replace missing values with their means. Instead, a separate category was created. There was no change in the level of significance among the income categories, nor the overall model.

Table 5. Impact of Controls, Gender, Class and Socioeconomic Position on Health Related Need: Cognitive Ability (MMSE)

	Model 1		Model 2		Model 3	
	b	**SE**	**b**	**SE**	**b**	**SE**
Age	-3.18	0.46***	-3.20	0.46***	-2.95	0.44***
Unmarried/alone	4.05	7.74	3.70	8.20	11.79	8.61
Unmarried/others	-9.57	9.11	-12.02	9.34	-3.35	9.56
Gender			9.04	9.10	6.41	8.39
Professionals			30.43	12.58*		
Semi-skilled labour			-11.67	10.75		
Unskilled labour			-16.14	17.02		
Homemakers			-9.12	9.35		
Income category 1					-2.77	12.76
Income category 3					2.71	7.20
Income category 4					40.48	12.75**
Income category 5					55.25	19.64**
Education					-0.03	0.12***
Home ownership					-0.38	0.82
Assets					-1.93	0.78
Alpha	630.24	36.86***	627.95	38.05***	526.76	38.30***
R2		0.05		0.06		0.13
F		17.17***		7.39***		14.23***

*p<.05; **p. <.01; ***p<.001

5.2 The Impact of Gender and Class on Type and Extent of Care Received

In order to address the question of whether gender and class had an impact on the type of care services received, a multinomial logistic regression model was applied. Once again, the first model included control variables only, with gender, class, and socioeconomic position gradually introduced into the equation. Interaction terms between gender, class and income (as a measure of socioeconomic position) were to be tested if warranted based upon levels of significance of the main effects in prior models.

When results from the multinomial regression analysis were examined, it was found that none of the models were significant at a level of .05 or greater. Model 1, which included marital status and living arrangements, had a chi-square value of 9.91 with 6 degrees of freedom. Model 2, which examined gender and class as well as control variables, had a chi-square value of 23.91 with 18 degrees of freedom, and model three which examined socioeconomic position had an even lower chi-square value of 18.11 with 20 degrees of freedom[15]. None of the variables tested were found to be significant, indicating very strongly that age, marital status, gender, class and socioeconomic position alone or in combination with one another are not significant predictors of whether older adults access home care services, or the type of care accessed. Consequently, analysis was not pursued further.

The impact of gender and class on the extent of home care services received was assessed by focussing on the total number of care hours received by all service users. Control variables were introduced into the regression models first, followed by gender and class or socioeconomic position. Table 6 presents the findings for extent of care among all in-home care users.

Once again, the overall model is not significant, and none of the social or socioeconomic variables are found to be significant predictors of the extent of home care services received. Clearly, the receipt and extent of in-home care services (including

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[15] Income was also tested without replacing missing values with the mean for both type and extent of care received. There were no changes in the levels of significance when missing values were tested as a separate category.

housekeeping, meal preparation and personal care) are not significantly associated with gender, class or socioeconomic position in the absence of health status.

Table 6. Extent of Services Accessed by all Service Users

	Model 1		Model 2		Model 3	
	b	**SE**	**b**	**SE**	**b**	**SE**
Age	0.00	0.01	0.01	0.01	0.00	0.01
Unmarried/alone	-0.15	0.10	-0.14	0.11	-0.09	0.11
Unmarried/others	-0.03	0.12	-0.04	0.12	0.03	0.13
Gender			-0.02	0.12	-0.05	0.11
Professionals			0.02	0.16		
Skilled labour			-0.16	0.13		
Semi-skilled labour			-0.13	0.14		
Unskilled labour			0.15	0.20		
Homemakers			-0.12	0.12		
Income category 1					0.00	0.16
Income category 3					-0.00	0.09
Income category 4					-0.13	0.17
Income category 5					0.23	0.28
Education					0.01	0.01
Home ownership					0.12	0.01
Assets					-0.03	0.09
Alpha	6.13	0.46***	6.23	0.48***	5.90	0.51***
R2		0.00		0.01		0.01
F		1.01		0.81		0.75

*p<.05; **p. <.01; ***p<.001

5.3 The Impact of Gender, Class and Health Need on Type and Extent of Care Received

In order to further investigate relationships between gender, class and health need in relation to the type and extent of care received, several models have been tested. The first model applies multinomial logistic regression in testing the influence that health needs, gender and class have on the type of care received. The second model tested examines health-related need, gender and socioeconomic position on the type of in-home care services received. Interaction terms between gender and health need (ADL, IADL and MMSE), class and health need and socioeconomic position and health-related need are also tested.

The model which tested the impact of gender, class, health-related need, age and marital status/living arrangements, was found to be significant at the .001 level (Chi-square=257.52, df=24). Not surprisingly, ADL and IADL impairment were highly significant predictors ($p < .001$) of the type of service utilized by respondents. Interestingly, the measure of cognitive functioning was determined to be less strong as a predictor of type of service received than the other two health measures ($p < .01$). Marital status/living arrangements was also found to be significant in this model ($p < .05$). The expected probabilities for these variables are presented in Tables 7 through 10[16]. Neither gender nor class were found to be significant.

When all other variables are held at their mean values, using married women who report being managers or technicians as a reference group[17], we find that as levels of functional ability associated with basic activities of daily living decreases, so too does the probability of receiving both home nursing and home support services. Of particular interest here though is that as functional ability decreases, the likelihood of receiving services at all decreases. For example, among those with a comparatively low level of

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[16] Values of the coefficients may be found in Appendix F.

[17] Although homemakers comprise the largest single category of class status, and the largest group is generally used as a reference category, neither the Pineo-Porter-McRoberts scale of occupational standing, nor any other measure of occupational class, has explicitly included this group in their measures of class standing. Thus, the second largest occupational category has been selected as a reference to ensure that meaningful analysis is possible among other formally recognized classes.

disability (5), 28.3% do not receive any services compared to 40.1% of those with high levels of disability (30).

Table 7. Type of Service Received by Gender and Class: Expected Probabilities by ADL Disability

	Do not Receive any Service	Home Support Services Only	Both Home Nursing and Home Support
5 - good	28.3%	71.3%	0.4%
10	36.4%	61.5%	2.0%
15	40.5%	54.1%	5.4%
30 - poor	40.1%	35.9%	24.0%

A similar trend is evident when examining cognitive ability in relation to receipt of services[18]. As seen in Table 8, 58.6% of those with a high level of cognitive impairment (a score of 5) do not receive either home support or home nursing care services, whereas only 12.3% of those with a high level of cognitive functioning (a score of 30) do not receive any form of service. However, as was the case with basic activities of daily living, as levels of cognitive functioning decrease, the expected probability of receiving both home support and home nursing care increase. Thus, although those with a high level of cognitive impairment (5) are less likely to receive services at all, when they do receive services, they are more likely to receive both home support and home nursing care (2.5%) than those who have a high level of cognitive ability (30) among whom only 1.1% receive both home nursing and home support services.

Unlike measures of basic activities of daily living and cognitive ability, we find that as disability associated with instrumental activities of daily living increases so too do the expected probabilities of receiving some form of service. As is reflected in Table 9, 83% of those with a relatively low level of disability (6) surrounding instrumental tasks do not receive any form of service, whereas 4.2% of those with a high level of disability do not receive any form of service. We also find that as functional decline increases so too does the probability of receiving both home nursing and home support services.

[18] Unlike the measures of ADL and IADL disability, a lower MMSE score indicates a high level of cognitive impairment.

Table 8. Type of Service Received by Gender and Class: Expected Probabilities by Cognitive Ability (MMSE)

	Do not Receive any Service	Home Support Services Only	Both Home Nursing and Home Support
5 - poor	58.6%	38.9%	2.5%
10	53.8%	43.7%	2.5%
20	34.7%	63.3%	2.0%
30 - good	12.3%	86.6%	1.1%

Table 9. Type of Service Received by Gender and Class: Expected Probabilities by IADL Disability

	Do not Receive any Service	Home Support Services Only	Both Home Nursing and Home Support
6 - good	83.0%	16.7%	0.3%
15	45.7%	52.7%	1.6%
25	10.5%	84.2%	5.3%
30 - poor	4.2%	87.8%	8.0%

Table 10 presents the expected probabilities of type of service received by marital status and living arrangements. Once again, all independent variables were held at their mean values with women who were managers or technicians used as the reference group. Those women who were unmarried and who lived alone were the most likely to receive home support services (73.8%) and the least likely not to receive any service (23.1%). Those who were currently married and living with a spouse were the most likely group not to receive services (36.6%) while those who were unmarried and living with others were the least likely to receive both home nursing and home support services (30.4%).

Table 10. Type of Service Received by Gender and Class: Expected Probabilities by Marital Status

	Do not Receive any Service	Home Support Services Only	Both Home Nursing and Home Support
Married	36.6%	61.3%	2.1%
Unmarried/alone	23.1%	73.8%	3.1%
Unmarried/others	30.4%	67.7%	1.9%

When socioeconomic position as measured through income, education, the presence of assets and home ownership was examined in relation to the type of service received rather than occupational class or standing, an error associated with too few respondents in the highest income category made meaningful analysis impossible[19]. Since one of the primary interests of this study is to examine class differences, and the ambiguity surrounding homemakers as an occupational group, it was felt that the inclusion of income in assessing differences in socioeconomic position and portion that respondents paid for in-home care services, the income variable was transformed from 5 categories to 4. The income groups in this analysis were coded as:

1) Gross yearly income of $9,000 or less (6.7%)
2) Gross yearly income between $9,001 and $14,988 (41.4%)
3) Gross yearly income between $15,000 and $29,988 (41.2%)
4) Gross yearly income of $30,000 and greater (10.7%)

Once the model was tested using the modified income variable, it was found to be highly significant (Chi-square 253.42; df 26; $p < .000$). Measures of physical functioning (ADL and IADL) were found to be the strongest predictors of the type of services received ($p < .001$). Cognitive ability was found to be a slightly less strong predictor of care services received ($p < .01$). Finally, marital status/living arrangements was found to be significant at the .05 level.

Although expected probabilities were necessarily different given the different composition and measurement of the variables, there were no differences in the patterns

[19] The error itself was a quasi-separation of the data. When there are too few cases in a given category, in this case most likely too few respondents who reported income over $60,000 a year (2.9%) receiving services, data analysis becomes impossible as comparisons between these groups is not possible, making the overall model ineffective.

of receipt of care by ADL, IADL, cognitive functioning or marital status between this analysis and the analysis involving occupational measures of class. Given that there are no significant differences in the patterns of care in these models, the findings associated with socioeconomic position are not presented here (see Appendix G for raw coefficient score and expected Probabilities).

The final model tested interaction terms between gender and health, class and health and income and health were also tested in relation to the type of services received. None of the interactions were found to be significant and consequently, further analysis of these models was not pursued.

In order to examine if there are differences in the number of care hours received by those who access home care services and if this differs by gender, class or socioeconomic position[20] and health-related need[21], ordinary least squares regression analysis was again applied. Table 11 presents the results of ordinary least squares regression analysis for the number of care hours received among all service users. As seen in model 1, physical functioning as expressed through measures of instrumental and basic activities of daily living are once again found to be highly significant ($p< .001$), while cognitive ability is not a significant predictor in determining the number of care hours received. The overall model explains 19% of total variance and is significant at the .001 level.

Models two and three present results from the regression analysis when gender and class are entered into the equation. Results from these analyses indicate that neither gender nor occupational class are effective predictors of the number of hours of care. Indeed, when gender is entered into the model in the absence of class, we find that the amount of variance explained by the model is less (18%) than when health, age and marital status/living arrangements alone are considered. When class is entered into the equation, there is only modest improvement in the overall variance explained (20%).

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[20] The income variable was also tested without replacing missing values with the mean values. Instead a separate category was created for missing values. Findings revealed that there were no changes in the levels of significance for the income variable when missing values were included or omitted.

[21] Once again, all four models were tested using both a quadratic term for MMSE, as well as an untransformed variable. Findings indicate that there were no changes in the R2 values when the untransformed variable was tested (model 1, R2=0.19; model 2, R2=0.19; model 3. R2=0.20; model 4, R2=0.22.

When socioeconomic position is entered into the overall equation, we once again find that physical functioning is significant at the .001 level. Once again, home ownership is also found to be significant at the .01 level, indicting that those who own their homes receive more care hours than those who do not. Interestingly, while education was not found to be a significant predictor of care hours among those who received home support services only, education is found to be significant at the .05 level in determining the extent of care received when all service users are considered. Findings here indicate that those with higher levels of education receive slightly more care hours than those with less educational attainment. When interaction terms between gender and health, income and health, and education and health were tested in relation to the number of care hours received by all service users, no significant findings were obtained.

Table 11. Number of Care Hours Received Among Service Users by Gender, Class and Socioeconomic Position: Measures of Health Need

	Model 1		Model 2		Model 3		Model 4	
	b	**SE**	**b**	**SE**	**b**	**SE**	**b**	**SE**
Age	0.01	0.01	0.01	0.01	0.00	0.01	0.00	0.01
Unmarried/alone	-0.14	0.09	-0.09	0.09	-0.09	0.10	0.01	0.10
Unmarried/others	-0.14	0.11	-0.10	0.11	-0.11	0.11	-0.05	0.11
ADL	0.85	0.16***	0.87	0.16***	0.90	0.16***	0.87	0.16***
IADL	0.04	0.01***	0.04	0.01***	0.04	0.01***	0.05	0.01***
MMSE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Gender			-0.17	0.10	-0.16	0.11	-0.14	0.10
Professionals					0.08	0.15		
Skilled labour					-0.23	0.13		
Semi-skilled labour					-0.21	0.12		
Unskilled labour					0.00	0.20		
Homemakers					-0.09	0.11		
Income category 1							-0.03	0.15
Income category 3							0.02	0.15
Income category 4							0.03	0.15
Income category 5							0.45	0.25
Education							0.03	0.01*
Home ownership							0.20	0.08**
Assets							-0.02	0.08
Alpha	4.26	1.03***	4.25	1.03***	4.30	1.03***	3.82	1.04***
R2		0.19		0.19		0.20		0.22
F		23.92***		21.38***		13.81***		12.85***

*p<.05; **p. <.01; ***p<.001

5.4 The Impact of Social Resources, Gender, Class, and Health Need on Patterns of Care

To address the question of whether social resources alone or in combination with other factors such as gender, class or socioeconomic position and health influence either the type or extent of care received, multinomial logistic regression and OLS regression models were once again applied.

Multinomial regression was first applied in order to determine the impact of social resources on the type of care received. Initial models included control variables, health status, gender and class in addition to variables that measured the number of family members, friends or neighbours that the respondent knew. The overall model was found to be significant at the .001 level (Chi-square=280.22, df =30). Neither gender nor class were found to be significant predictors of the type or extent of in-home care services received once informal social networks were entered.

However, physical functioning as expressed through measures of instrumental and basic activities of daily living, was found to be highly significant ($p< .001$). Cognitive ability was also a significant predictor of the type of care accessed (p. <.01), as was marital status ($p <.05$). Although the numbers of friends and neighbours that respondents reported knowing were not found to be significant predictors of the type of care accessed by older adults, the number of family members that respondents reported was found to be highly significant ($p< .001$). Neither gender nor class were found to be significant. In determining the probabilities of receiving services, all other variables are held at their mean values and married women who were managers or technicians was used as the reference group[22].

Tables 12, 13 and 14 present the expected probabilities for type of service received by basic and instrumental activities of daily living as well as cognitive functioning. Consistent with previous models examining the type of care received by basic activities of daily living, we find that as levels of disability increase, the probability of receiving home support services only decreases, and of receiving both home nursing and home support increases. However, the likelihood of not receiving any services also appears to increase. With regard to cognitive impairment (see Table 13), as levels of

[22] Raw coefficient score may be found in Appendix H

functioning decrease, the probability of receiving home support services only decreases, while the probability of receiving both home nursing and home support increases. When examining the expected probabilities of type of service received in relation to instrumental activities of daily living, we find that as levels of functioning decrease, so too does the likelihood of receiving some form of service.

Table 12. Type of Service Received by Gender, Class and Informal Networks: Expected Probabilities by ADL

	Do not Receive any Service	Home Support Services Only	Both Home Nursing and Home Support
5 - good	26.8%	72.8%	0.4%
10	36.4%	61.5%	2.1%
15	41.5%	53.1%	5.4%
30 - poor	43.1%	34.3%	22.6%

Table 13. Type of Service Received by Gender, Class and Informal Networks: Expected Probabilities by Cognitive Impairment (MMSE)

	Do not Receive any Service	Home Support Services Only	Both Home Nursing and Home Support
6 - poor	58.8%	38.7%	2.5%
10	54.0%	43.6%	2.5%
20	34.7%	63.2%	2.1%
30 - good	12.2%	86.6%	1.1%

Table 14. Type of Service Received by Gender, Class and Informal Networks: Expected probabilities by IADL

	Do not Receive any Service	Home Support Services Only	Both Home Nursing and Home Support
5 - good	84.9%	14.9%	0.2%
15	46.3%	52.1%	1.6%
25	9.6%	85.0%	5.4%
30 - poor	3.5%	88.3%	8.1%

When marital status/living arrangements was examined in relation to the type of service received (see Table 15), the findings indicated that those who were married were most likely to go without formal services (26.6%). Those who were unmarried and living alone were the most likely to receive in-home care services, with 74.2% of those in this group receiving home support services only and 3.3% receiving both home nursing and home support. Those who were unmarried and living with others were less likely to receive some form of service (30.5%) than those who were married (36.6%), but not as likely to receive services than those who lived alone (22.5%), indicating that the presence of a spouse or other person to provide care does indeed have an impact on the receipt of formal in-home care services. This finding is further supported when examining the impact of the number of family members the respondent has in relation to the type of care received.

Table 15. Type of Service Received by Gender, Class and Informal Networks: Expected Probabilities by Marital Status/Living Arrangement

	Do not Receive any Service	Home Support Services Only	Both Home Nursing and Home Support
Married/other	36.6%	61.3%	2.1%
Unmarried/alone	22.5%	74.2%	3.3%
Unmarried/others	30.5%	67.6%	1.9%

As reflected in Table 16, as the number of family members increases, so too does the probability that in-home care services will not be utilized. Although the probability of receiving both home nursing and home support is only marginally affected by the increase in the number of family members, the probability of receiving home support services only significantly decreases.

Table 16. Type of Service Received by Gender, Class and Informal Networks: Expected Probabilities by Family Members

	Do not Receive any Service	Home Support Services Only	Both Home Nursing and Home Support
1	26.8%	70.9%	2.3%
5	35.3%	62.5%	2.2%
9	44.8%	53.2%	2.0%
12	52.3%	45.9%	1.8%

Similar analyses were conducted to examine socioeconomic position in relation to type of care accessed. Once again, there was a separation of the data with the original income variable making analysis impossible. To correct this, income was once again truncated, leaving the highest income category of $30,000 or greater, which made up 10.9% of the total sample[23]. Once again, the overall model was significant (Chi-square=273.40, df=32; $p < .001$). Within the model itself, functional ability associated with basic and instrumental activities of daily living, cognitive ability, and the number of family members reported were found to be significantly related to the type of care accessed when gender, age, marital status/living arrangements and socioeconomic position were considered.

Once again, although differences are evident in terms of the expected probabilities and specific types of service being received due to the composition and measurement of variables, the overall patterns remain the same and consequently, are not presented here (see Appendix I for raw coefficient scores and expected probabilities).

To determine if informal social networks have an impact on the extent of care received among those who received home care services, OLS regression analysis were once again conducted. Initially, the equation included social network variables along with control variables. Succeeding models added gender, class socioeconomic position and health-related need to the equation.

As reflected in Table 17, basic and instrumental activities of daily living are significant ($p < .001$) predictors of the number of care hours received, and indicate that as physical disability increases so does the number of service hours provided. However, the number of friends, family members and neighbours reported are not significant when included in the analysis along with control variables, gender, class or socioeconomic position in determining the amount of care received. As was the case in previous models that examined the number of home support hours received without the inclusion of informal social networks, there is a correlation between the number of home support hours received and home ownership ($p < .01$).

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[23] This model was also tested with the income variable that had a separate category for missing values instead of replacing missing values with the mean. Findings indicate that there was no change in the level of significance when this alternate formulation of the income variable was tested

Table 17. Extent of Care by Gender, Class, Socioeconomic Position and Informal Networks

	Model 1 Gender and Class		Model 2 Socioeconomic Position	
	b	**SE**	**b**	**SE**
Age	0.00	0.01	0.01	0.01
Unmarried/alone	-0.08	0.10	0.01	0.10
Unmarried/others	-0.08	0.11	0.02	0.11
ADL	0.91	0.16***	0.88	0.16***
IADL	0.05	0.01***	0.05	0.01***
MMSE	0.00	0.00	0.00	0.00
Gender	-0.16	0.11	-0.14	0.10
Professionals	0.03	0.15		
Skilled labour	-0.22	0.12		
Semi-skilled labour	-0.23	0.12		
Unskilled labour	0.01	0.19		
Homemakers	-0.11	0.11		
Income category 1			-0.47	0.28
Income category 3			-0.45	0.25
Income category 4			-0.46	0.24
Income category 5			-0.47	0.27
Education			0.03	0.01*
Home ownership			0.22	0.08**
Assets			-0.04	0.08
Family	0.00	0.01	0.00	0.01
Friends	0.01	0.01	0.00	0.01
Neighbours	0.00	0.01	0.00	0.01
Alpha	4.30	0.61***	3.82	1.05
R2		0.19		0.23
F		11.65***		11.15***

*p<.05; **p. <.01; ***p<.001

5.5 Portion of Payment

In order to examine private-public mix with regard to the utilization of in-home care services, multinomial logistic regression analyses were also used to examine the impact of gender, class and other predictors of payment of services received. Three categories make up the dependent variable: (1) pay nothing, (2) pay for a portion of services received, and (3) pay for all services received. All service users were included in the analysis. Initial models incorporated age, marital status/living arrangements, gender, class, and informal social networks. Next, measures of class were excluded and replaced by measures of socioeconomic position.

The model that included gender and class was found to be significant at the .001 level (Chi-square 191.239, df 30). Instrumental activities of daily living, age and class emerged as highly significant predictors of portion of payment ($p < .000$). Informal social networks in the form of marital status and living arrangements ($p < .01$) and the number of family members and friends that the respondent reported knowing ($p < .05$) were also found to be significant[24].

When all variables are held at their mean values and women who are married and are managers or technicians are held constant, we find that as age increases, the expected probability of not paying for in-home care service decreases, and the likelihood of paying for a portion or in full for services received increases (Table 18). For example, while 71.2% of those aged 90 would be expected to pay for all of the services they received, this is the case for only 47.2% of those 70 years of age.

Table 18. Portion of Payment by Gender, Class and Informal Networks: Expected Probabilities by Age

	Pay none	Pay some	Pay all
70	29.0%	23.7%	47.2%
80	25.3%	14.5%	60.2%
90	20.5%	8.3%	71.2%

[24] Raw coefficient scores for these models are presented in Appendix J

Table 19 presents the findings for portion of payment by level of functioning with regard to instrumental activities of daily living. Not surprisingly, as level of functional ability decreases, so too does the likelihood of having to pay for any portion of in-home care services received.

Table 19. Portion of Payment by Gender, Class and Informal Networks: Expected Probabilities by IADL

	Pay none	Pay some	Pay all
6 -good	11.5%	5.3%	83.2%
15	21.5%	11.1%	67.4%
25	35.5%	20.8%	43.7%
30 - poor	41.7%	26.1%	32.2%

Table 20 presents the expected probabilities of portion of payment by class. As class status is tied to income, it is not surprising that those with higher class status are more likely to pay for a portion or in full for the in-home care services they receive. What is of interest however, are the expected probabilities for homemakers.

Table 20. Portion of Payment by Gender, Class and Informal Networks: Expected Probabilities by Occupational Class

	Pay none	Pay some	Pay all
Professional	12.5%	26.5%	61.1%
Manager	24.2%	12.8%	63.1%
Skilled work	42.9%	27.2%	29.9%
Semi-skilled work	45.2%	17.0%	37.9%
Unskilled work	62.0%	20.3%	17.7%
Homemakers	31.6%	14.4%	54.0%

With marital status controlled for, the findings indicate that about 32% of those who reported being homemakers could be expected to receive fully subsidized public service, 14% could be expected to pay for a portion of the services received, while 54% could be expected to pay for all services received. When comparing these results to those for other occupations, we find that homemakers (68.4%) are less likely to pay for in-home care services than are professionals (87.6%) or managers (75.8%), but more likely

to pay for a portion or in full for services than are skilled workers (57.9%), semi-skilled workers (54.9%) or unskilled workers (38.0%). Because many scales of occupational standing have excluded this group, interpretation of these findings is difficult. Given that the women themselves did not identify their class standing, it is difficult to know if the findings related to homemakers may be attributed to their partner's class status, the class status attributed to them through their families of origin, or some other factor that has not been well explored.

The expected probabilities of portion of payment by marital status/living arrangements (presented in Table 21) reveal some interesting differences among those who are married and live with their partner, those who are unmarried and live alone and those who are unmarried and live with others. Specifically, findings indicate that those who are married and living with their spouse are the least likely of all groups to receive fully subsidized services (24.2%), while those who are unmarried and live with others are the most likely to receive fully subsidized services.

Table 21. Portion of Payment by Gender, Class and Informal Networks: Expected Probabilities by Marital Status/Living Arrangements

	Pay none	Pay some	Pay all
Married/spouse	24.2%	12.8%	63.1%
Unmarried/alone	31.9%	17.1%	51.0%
Unmarried/others	44.3%	12.0%	43.7%

However, although 32% of those who are unmarried and live alone have an expected probability of receiving fully subsidized service (more than those who are married but less than those who are unmarried and live with others), they are the most likely to pay for a portion of the services they receive (17%). Those who are married and live with a spouse are less likely to pay for a portion of services, but are more likely to pay for all of the services they receive (63%).

When informal social networks are considered in relation to the portion of services that in-home care users will pay for (Table 22), we find that as the number of family members increases so too does the probability of not having to pay for service.

Table 22. Portion of Payment by Gender, Class and Informal Networks: Expected Probabilities by Number of Family Members

	Pay none	Pay some	Pay all
1	17.7%	12.9%	69.4%
3	20.4%	12.9%	66.8%
6	30.0%	12.4%	57.6%
9	35.6%	12.0%	52.4%

When examining the impact of the number of friends in relation to the expected probabilities of portion of payment, the findings reveal that in contrast to the number of family members, those with greater numbers of friends are less likely to receive fully subsidized services, and are more likely to pay for all the services received.

Table 23. Portion of Payment by Gender, Class and Informal Networks: Expected Probabilities by Number of Friends

	Pay none	Pay some	Pay all
0	30.7%	11.5%	57.8%
3	27.2%	12.2%	60.6%
6	23.9%	12.8%	63.3%
9	21.0%	13.4%	65.6%

The second model examined the portion that respondents were likely to pay in relation to age, health status, gender, informal social networks and socioeconomic position. Once again, when this model was initially tested, an error associated with too few respondents in the highest income category made meaningful analysis impossible[25]. Therefore, as with previous analysis, the income variable was transformed from 5 categories to 4, with those earning $30,000 or greater representing the highest income group.

[25] The error itself was a quasi-separation of the data. When there are too few cases in a given category, in this case most likely too few respondents who reported income over $60,000 a year (2.9%) receiving fully subsidized services, data analysis becomes impossible as comparisons between these groups is not possible, making the overall model ineffective.

Once the model was tested using the modified income variable, it was found to be significant at the .001 level (Chi-square=296.172, df=32)[26]. Interestingly, there are a number of differences between this model and the model examining class. For example, although instrumental activities of daily living was significant at the .001 level when examining class, basic activities of daily living was not. In this model, we find that disability in instrumental activities of daily living is once again significant at the .001 level, but in addition, we see that disability with regard to basic activities of daily living is also significant at the .05 level.

When examining informal social networks in this model, we find that the number of family members is once again a significant predictor of portion of payment ($p<.01$), but the number of friends that respondents have is not ($p=.214$). There were also differences between the model examining class and the model examining socioeconomic position in relation to gender. While gender was not found to be significant in relation to portion of payment when class was considered, gender is significant (at the.05 level) when measures of socioeconomic position are entered.

The only measures of socioeconomic position that were found to be significant in relation to portion of payment were income ($p<.001$) and education ($p<.01$). Home ownership and the presence of assets were not significantly related to the expected probabilities that respondents would have to pay for some all or none of their in-home care services. Age was also highly significant ($p<.001$) in determining the portion of payment[27].

In calculating the expected probabilities for significant independent variables, all variables were held at their mean values with married women who owned their homes and had assets with an income between $9,001 and $14,998 used as the reference group.

Table 24 presents the expected probabilities for portion of payment by age. As was the case with previous models examining age, it would appear that as age increases, there is a greater probability of paying for all the services received. At age 70, there is a 78.4% expected probability of receiving fully subsidized service, whereas at age 80 there

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[26] This model was also tested using the alternate income variable that had a separate category created for the missing values instead of replacing missing values with the mean. There was no significant change in the level of significance of the overall model, nor in the level of significance for the income variable itself.

[27] Raw coefficient scores are presented in Appendix K.

is a 78.5% probability of receiving fully subsidized service which declines to 76.4% at age 90.

Table 24. Portion of Payment by Gender, Socioeconomic Position and Informal Networks: Expected Probabilities by Age

	Pay none	Pay some	Pay all
70	78.4%	13.8%	7.8%
80	78.5%	9.8%	11.6%
90	76.4%	6.8%	16.8%

When assessing the importance of functional ability in relation to both basic and instrumental activities of daily living in determining the portion that the recipients of in-home care services will have to pay, we find that as levels of disability increase, the likelihood of receiving fully subsidized services increase as well, with the probability of paying for all services received decreasing (Tables 25 and 26).

Table 25. Portion of Payment by Gender, Socioeconomic Position and Informal Networks: Expected Probabilities by IADL

	Pay none	Pay some	Pay all
6	69.1%	6.0%	24.9%
15	77.1%	8.5%	14.5%
25	81.2%	11.5%	7.4%
30	81.7%	13.1%	5.2%

Table 26. Portion of Payment by Gender, Socioeconomic Position and Informal Networks: Expected Probabilities by ADL

	Pay none	Pay some	Pay all
5	61.1%	17.6%	21.3%
10	78.0%	9.1%	12.9%
20	88.9%	4.2%	6.9%
30	92.7%	2.6%	4.7%

Table 27 presents the expected probabilities for marital status/living arrangements. The findings reflect that those who are unmarried and live alone are the most likely to have to pay for some or all of the services they receive, and are the least likely to receive fully subsidized services (63.5%) as compared to those who live with a spouse (78.2%) or live with others at the same level of health need (77.8%). In addition, those who live with their spouse are more likely to pay for all of their in-home care services (12.8%) than those who live with someone other than their partner (11.5%).

Table 27. Portion of Payment by Gender, Socioeconomic Position and Informal Networks: Expected Probabilities by Marital Status/Living Arrangements

	Pay none	Pay some	Pay all
Married/spouse	78.2%	9.0%	12.8%
Unmarried/alone	63.5%	17.7%	18.7%
Unmarried/other	77.8%	10.7%	11.5%

When the expected probabilities for number of family members in relation to portion of payment are calculated, we find a simple linear relationship. As the number of family members increases, the likelihood of paying for a portion or in full for services decreases, and the probability of receiving fully subsidized services increases.

Table 28. Portion of Payment by Gender, Socioeconomic Position and Informal Networks: Expected Probabilities by Number of Family Members

	Pay none	Pay some	Pay all
1	69.8%	11.7%	18.4%
3	73.7%	10.5%	15.8%
6	78.9%	8.8%	12.3%
9	83.3%	7.2%	9.5%

When all other variables are held constant, the findings indicate that 83.8% of men received fully subsidized services, whereas only 78.2% of women received services

that were fully paid for. In addition, we find that women are twice as likely (12.8%) to pay for all the services they receive as men (6.4%).

Table 29. Portion of Payment by Gender, Socioeconomic Position and Informal Networks: Expected Probabilities by Gender

	Pay none	Pay some	Pay all
Men	83.8%	9.8%	6.4%
Women	78.2%	9.0%	12.8%

Although there is a generally linear relationship between income and portion of payment, with those who earn more having a greater expected probability that they will pay for as portion or in full for all services received, there appears to be one exception. As reflected in Table 30, those in the lowest income bracket earning $9,000 a year or less, are more likely to have to pay for all services received, and are less likely to receive fully subsidized services than those who report an income between $9,001 and $14,988. However, these findings may be attributed to the relatively small proportion of respondents who reported an annual income of $9,000 or less.

Table 30. Portion of Payment by Gender, Socioeconomic Position and Informal Networks: Expected Probabilities by Income

	Pay none	Pay some	Pay all
Gross yearly income of $9,000 or less	75.3%	8.1%	16.7%
Gross yearly income $9,001 - $14,988	78.2%	9.0%	12.8%
Gross yearly income $15,000 - $29,988	35.5%	14.3%	50.2%
Gross yearly income of $30,000 and greater	11.3%	12.8%	75.9%

A similar relationship can be seen in Table 31, which examines education. As the number of years of education that respondents report increases, so too do the expected probabilities of paying for some or all of in-home care services received.

Table 31. Portion of Payment by Gender, Socioeconomic Position and Informal Networks: Expected Probabilities by Education

	Pay none	Pay some	Pay all
9	81.9%	7.8%	10.3%
12	77.0%	9.4%	13.6%
15	71.2%	11.1%	17.7%
18	64.6%	12.9%	22.5%

Given the significant differences between the findings obtained when class or socioeconomic position is entered, interaction terms were tested among only those variables that were significant when either class or socioeconomic position were tested. The results indicated that none of the interactions were significant and further analysis was not pursued.

Chapter 6: Discussion and Conclusions

The central purpose of this study was to examine relationships involving gender, class status, health-related need (as defined by policy) and access to in-home care services among community dwelling older adults. Specifically, this study addressed gender and class differences in health status, utilization of in-home care services, the extent of care received and public subsidy of care. A political economy theoretical framework guided the study. This framework views public policy as an expression of power relations and the welfare state as a system of stratification. Five specific research questions were formed in order to examine gender and class differences in access to in-home care services:

1. What impact do gender and class have on health-related need as defined by health policy?

2. What impact do gender and class have on the type as well as the extent of in-home care received?

3. What impact do gender and class have on the relationship between health needs as defined by policy and the type and extent of in-home care received?

4. What impact do informal social networks have on relationships involving gender, class, health-related need and the type and extent of care received?

5. What impact do gender, class, health-related need and informal social networks have on access to publicly-financed care?

To investigate relationships between gender and class and health-related needs as articulated through policy, whether the receipt of care varies by class position and gender, who is most likely to receive publicly subsidized care and the impact of informal social networks on the receipt of publicly subsidized care in the province of British Columbia, ordinary least squares and multinomial logistic regression analyses were applied using secondary data drawn from the Victoria Patterns of Care Project carried out in 1996.

The following section presents a summary of the findings obtained from each research question and is followed by discussion of the implications of the findings. The limitations of the study are also addressed and future research directions proposed.

6.1 Summary of Findings

6.1a Gender, Class and Health Status

In order to determine if gender or class influenced health-related needs, ordinary least squares regression was applied to measures of functional ability as they were conceived in the LTC1, the measurement instrument used by the province to determine eligibility for in-home care services.

Unlike previous studies (Arber and Ginn, 1991; Cairney and Arnold, 1996; Glaser and Grundy, 2002; Mustard et al, 1997; Wilkins and Park, 1998), the only significant relationship between class and health-related functioning in this sample was a weak relationship between those professional class status and cognitive ability. Although class was not found to be a significant predictor of physical functioning, there was a relationship between education and income and the likelihood of experiencing functional disability with instrumental activities of daily living and cognitive impairment, which is consistent with prior literature (Cairney and Arnold, 1996; Segall and Chappell, 2000; Wilkins and Park, 1996). Findings presented here also support prior literature indicating that women are more likely to experience greater health limitations as expressed through measures of activities of daily living (Cairney and Arnold, 1996; Chen and Wilkins, 1998; Wilkins and Park, 1996).

This study also offers support to prior research that has shown that other social factors are often predictors of health and functioning in later life (Cairney and Arnold, 1996; Chen and Wilkins, 1998; Crowell et al., 1996; Duncan, 2002; Hubert et al., 1993; Humphries and Doorslaer, 2000; Millar, 1995; Mustard et al., 1997; Navarro, 2002; Poland et al., 1998; Wilkins and Park, 1996). Interestingly, age alone and in combination with other variables including marital status, gender, class and socioeconomic position, was not found to be a significant predictor of ADL disability which is generally considered and only capture relatively severe levels of physical disability (McDowell and Newell, 1996). This finding supports the claim by other researchers that age per se is not a significant predictor of severe disability (Chen and Wilkins, 1998; Evans et al., 2001).

However, findings here also indicated that that there was a weak relationship between age and functional decline associated with instrumental activities of daily living,

which reflect activities associated with self-care and involve greater complexity capturing more moderate levels of functional disability (McDowell and Newell, 1996). Further, findings also indicated that as age increased, so did the likelihood of experiencing cognitive disability. This finding is congruent with prior literature, which has associated cognitive decline with advancing age (Tuokko et al., 1999; Wilkins and Park, 1996).

Prior literature suggests that those who are unmarried and live alone are at greatest risk of experiencing care needs associated with basic and instrumental activities of daily living (Chen and Wilkins, 1998). However, findings here suggest that those that were unmarried and lived with others were more likely to experience functional disability associated with both basic and instrumental activities of daily living. It is unclear why those who live with others may be the most likely to experience health related needs associated with basic activities of daily living. One possibility may be that this finding is a result of health needs as opposed to a predictor of health-related needs. Those with greater health related care needs may be more likely to move in with adult children or other sources of support instead of remaining in their homes alone and potentially having care needs go unmet. However, the exact relationship remains unclear.

6.1b The Impact of Gender and Class on Type and Extent of Care Received

Multinomial logistic regression was applied to determine if class or gender were determinants of the type of care received. Findings strongly indicate that neither of these social determinants of health were significant predictors of receiving in-home care. Further, when health was considered, analysis revealed no significant relationship between gender or class and the extent of care received. Thus, although social factors are often reported to be important determinants of health-related need, they are not accurate predictors of type or extent of care received among this sample.

When health-related need was entered into the models examining type and extent of care received, findings indicated that measures of physical functioning (both ADL and IADL) were strong predictors of the type and extent of care received. As health needs associated with instrumental activities of daily living increased, so too did the expected probabilities of receiving in-home care services and particularly, home support services.

Interestingly, among community dwelling older adults, basic activities of daily living, an indicator of severe functional impairment, was negatively associated with receiving in-home care services. Among those who had scores indicating high levels of functional impairment, 40.1% had an expected probability of not receiving any in-home care services, 35.9% received home support services only, while 24% received both home nursing and home support services.

The measure of cognitive ability, (MMSE), was found to be a somewhat weaker, though still significant, predictor of the receipt of in-home care services. The findings in this case were similar to those found in regards to basic activities of daily living. With a MMSE score of 5, the lowest score on the scale, 58.6% of respondents have an expected probability of not receiving any services, while only 38.9% received home support services alone and 2.5% received both home nursing and home support. Further, despite a substantial literature that argues that cognitive decline is associated with greater care needs (Chen and Wilkins, 1998; Clyburn et al., 2000; Tuokko et al., 1998; Wilkins and Park, 1998), cognitive impairment was found not to be a significant predictor in relation to the number of care hours received among home care service users in this sample.

As noted earlier, the IADL measure is considered an important measure in determining the suitability of in-home care (Hollander, 1996). Thus it may be seen as appropriate that those who have higher scores with respect to measures of instrumental activities of daily living are more likely than those with lower IADL scores to receive in-home care services. Measures of ADL disability and cognitive impairment are generally seen as representing more serious levels of illness and higher levels of care need indicating that institutional care may be considered more appropriate (Hollander, 1996; McDowell and Newell, 1996). However, this does not explain why older adults with high levels of care needs associated with basic activities of daily living and cognitive impairment who remain in the community would not receive home nursing and home-support services. One possible explanation may be that those with high levels of care needs are relying on informal supports for their care, and consequently not seeking out formal care services. Indeed, prior research indicates that informal care providers are often reluctant to utilize formal care services (Chappell et al., 2003; Jutras and Veilleux, 1991). Similarly, the assessment instrument, the LTC1, is vague surrounding the role of

informal social networks in determining care. An alternate reason for this finding may be that those with high levels of care needs may be deemed as ineligible for service because they are already receiving care from an informal care provider in order to remain independently in their home. Findings presented here also reveal that among those who did receive service, those with high levels of care need associated with activities of daily living (ADL) did receive a greater number of care hours than those who experienced limitations associated with instrumental activities of daily living (IADL).

Marital status and living arrangements were also found to be significant predictors of in-home care services received when health was taken into consideration. Among those who were unmarried and lived alone only 23.1% did not receive any sort of formal in-home care services. They were the most likely to receive both home nursing and home support services. Among those who were married and lived with others, 30.4% did not receive any form of in-home care services and among those who were married and lived with a spouse 36.6% did not receive care services.

Although previous models revealed that those who were unmarried and live with others are the most likely to experience health-related needs associated with basic activities of daily living, it would appear that they are less likely to receive formal care services than those who are unmarried and living alone. This may be a consequence of those with health-related needs choosing to co-reside with an adult child or other potential care provider in order to have their care needs met as opposed to this type of living arrangement serving as a predictor of health-related care need.

6.1c The Impact of Gender, Class and Health Need on Type and Extent of Care Received

In order to determine whether relationships between class and health as well as gender and health impact upon the type and extent of in-home care received, interaction terms between class and health-related needs and gender and health-related needs (as expressed through measures of ADL, IADL and MMSE disability) were created. Multinomial logistic regression analysis was then conducted to determine if these interactions were significant predictors of the type of care received. Similarly, OLS regression was used to determine if these interactions were significant indicators of the

number of care hours received. In both cases, interactions between gender, class and health-related needs were found not to be significant indicators of either the type or extent of care services received by older adults in the Capital Regional District of B.C.

The fact that interactions between gender and health-related need were not significant predictors of type and extent of care received indicates that the impact of health needs on the receipt of care as is similar among men and women. Thus, given similar levels of functional disability, older women were equally likely to receive services. Nevertheless, the analysis also found gender to be a significant predictor of functional disability in relation to basic activities of daily living as well as of cognitive decline. Further, other analyses presented here revealed that those who experience greater levels of disability associated with both activities of daily living as well as cognitive impairment were comparatively less likely to receive some form of in-home care service. Given that women are more likely to experience the types of health-related needs that are associated with a lesser probability of receiving in-home care services as levels of need increase, it is not unreasonable to speculate that women are less likely to receive in-home care services than are men.

6.1d The Impact of Informal Social Networks

Neither gender nor class were found to be significant predictors of the type or extent of in-home care services received once informal social networks were entered into the equation. However, findings from this study do indicate that as the number of family members increases, so too does the probability of not receiving any form of formal in-home care services, which may indicate that the presence of family members does play a role in the determining access to care. However, the number of friends and neighbours that the respondent knew was not found to be a significant predictor of the receipt of in-home care services.

Further, informal social networks were not found to be significant predictors of the number of care hours received among formal care users. Thus, although the presence of family members appears to play a role in determining whether or not care services are received, it did not appear to significantly impact the number of care hours received.

Physical health functioning was also found to be a highly significant predictor of the receipt of in-home care services when informal networks were considered. Consistent with previous models in this study, when the number of family members was held constant at the mean (5), findings indicated that as the level of ADL and cognitive disability increased, the expected probability of receiving any form of in-home care decreased. Findings surrounding instrumental activities of daily living (IADL) also followed the same pattern as previous models indicating that as levels of IADL disability increased so too did the expected probability of receiving in-home care services.

Patterns surrounding the extent of care were also consistent with previous models, indicating that although both ADL and IADL functioning were highly significant predictors of the number of care hours received, those who experienced functional decline associated with ADL received a greater number of care hours than those who experienced functional disability with instrumental activities of daily living.

6.1e Portion of Payment

To date, very little research has assessed how income testing may impact upon older adults' ability to access formal in-home care services (Norris et al., 1999; Vogel, 2001). Thus, the purpose of this model was to determine if those in different social locations, particularly women and those of varying class or socioeconomic positions, had equal access to publicly subsidized formal in-home care services.

In this case, social class was a significant predictor of the receipt of publicly subsidized services, with an expected probability of paying for some or all of the care services received as social class increases. Interestingly, for homemakers the expected probabilities of receiving fully subsidized in-home care services was 31.6%, which fell between managers and skilled labourers in terms of the social class scale.

While gender was not found to be a significant predictor of portion of payment when class was entered into the model, it was found to be significant when variables examining socioeconomic position were tested. Results indicated that women were significantly more likely than men to pay for some or all of the care services received, and were significantly less likely to received fully subsidized services. Although it

remains somewhat unclear as to why there appears to be a relationship between gender and portion of payment when socioeconomic position is entered as opposed to class, several possible explanations exist.

One possibility may surround the ambiguity of homemakers in relation to class status. While class, as conceptualized through the Pineo-Porter-McRoberts framework, may be an accurate measure of social standing and prestige, it may not accurately represent the current financial situations of many women who were homemakers and who are currently single or widowed who were dependent upon their husband's pension which may have been lost at the time of his death. Similarly, because all those who were classified as homemakers have been placed in one category, there may be significant variations in actual class status among this group, thus making the relationship between gender and class invisible.

Several measures of socioeconomic position including income and education, were also found to be significant predictors of portion of payment. Findings indicate that at a gross yearly earning of $9,000 or less, 75.3% of respondents paid for none of the services received, while at a gross yearly income between $9,001 and $14,988, 78.2% of respondents received fully subsidized services, with the expected probability of receiving fully subsidized services gradually declining as income increased.

Age was also determined to be a significant predictor of portion of payment with findings indicated that that as age increases, so too does the likelihood of paying for all of the services received. Findings also indicated that in relation to health status, the only consistently significant predictor of receiving fully subsidized, partially subsidized or privately paid for services was instrumental activities of daily living, with the expected probability of paying for none of the services received increasing with levels of IADL disability. Although ADL disability was determined to be a significant predictor of portion of payment when socioeconomic position was included in the model, it was not significant when class was entered into the model.

Marital status and living arrangements were also found to be significant predictors of portion of payment. Findings in this case consistently indicated that among those who accessed formal in-home care services, those who were unmarried and lived with others (e.g. widowed parents living with adult children) were the least likely to pay for services

while those who were married and living with their spouse the most likely to pay for all the services they received. Those who were unmarried and living alone were more likely to pay for services received than those who lived with others. Further, the presence of family members appears to have an impact on the portion that older adults will pay in relation to in-home care services. Although prior findings in this study indicated that as the number of family members reported increases, the probability of receiving services decreases, results surrounding portion of payment indicate that among those service users, those with larger family networks are less likely to pay for services received.

6.2 Discussion

Guided by a political economy theoretical framework, the central focus of this study was to explore class and gender differences among older adults in accessing in-home care services. As has been noted extensively throughout this study, a political economy approach suggests that the state, through social policy, may create or sustain social inequality associated with factors such as social class, gender and age.

In general, the findings from this study do not appear to support this claim in relation to class status. Although numerous other studies have found that class is linked to higher levels of morbidity, disability and chronic illness (Arber and Ginn, 1991; Cairney and Arnold, 1996; Humphries and Doorslaer, 2000; Mustard et al, 1997; Wilkins and Park, 1998), only a very limited relationship was found between class and health-related functioning in this study. Further, findings here indicated that class status was not a significant predictor of the receipt of in-home care services, nor the extent of care received.

In addition, although class status was a significant predictor of how much home care service users were required to pay for the services they received, when assessing class in relation to portion of payment, findings indicated that as class status increases, so too does the likelihood of paying for some or all of the care services received. However, when income was considered, findings indicated that those 75.3% of respondents reporting an annual income of $9,000 or less paid for none of the services received, while 78.2% of respondents with an annual income between $9,001 and $14,988 received fully subsidized services. These results would suggest that although income and class are often

highly correlated with one another, there appears to be some discontinuity between the two in this sample.

As noted earlier, the findings evident with regard to class may be attributed to the ambiguity of homemakers in relation to class status, and particularly to the decision to place homemakers in one category despite variations in actual class status among this group. This may have lead to an inaccurate representation of class as 35.8% of all the respondents were in this category. Further, given that class was not a significant predictor of the receipt of in-home care services, it is difficult to draw conclusions surrounding the impact that income-testing may have on access to home care services. Given this limitation, authoritative conclusions surrounding the impact of income testing creating or maintaining inequalities in relation to access to in-home care services are not possible.

While there is little evidence in this study to indicate that those with a low class status are not more likely to experience health-related care needs, and that the state, through social policy with regards to in-home care services, creates or maintains class inequalities, there is some evidence supporting such arguments when gender is considered. Specifically, this study found that women experience greater health limitations as expressed through measures of functional disability withy regard to basic activities of daily living. A political economy approach would suggest that reductions directed at health and social welfare programs may in fact disproportionately affect women, as they are more likely to need support services in order to retain their independence.

Findings presented here also revealed that those who experience greater levels of these types of disability were less likely to receive in-home care services, and that women were twice as likely as men to pay for all of the services they received and less likely to receive fully subsidized service than men, even when health was considered. Given that gender differences only emerged when socioeconomic position was considered, and the problems associated with the class variable, the significance of these results in showing gender-related inequalities in access to in-home care must be taken into question.

Nevertheless, it appears that older women may be less likely to receive care services than older men. One possible explanation for this may be that some older women, whose traditional role has been to maintain their home, may be reluctant to

divulge the extent of their functional limitations leading to an inaccurate assessment of health status and need making them ineligible for publicly subsidized service. Another possibility may surround gendered assumptions of ability surrounding many household activities such as housecleaning on the part of case managers during the assessment process based on traditional divisions of labour in the home. Although these assumptions may not be explicitly laid out in the assessment tool or process, it is not unreasonable to hypothesize that some case managers may make the assumption that women in this cohort, many of whom worked within the home, would be better able to clean, cook and tend house than older men who traditionally shared less of the household labour and responsibility.

Political economists have argued that the result of the adoption of neo-liberal ideologies on the part of the state has resulted in reductions of health and home care services. Indeed, prior research in B.C. has indicated the number of persons receiving in-home care services has recently declined (Segall, and Chappell, 2000). These findings suggest that it is older women, with high levels of care need that are disproportionately affected by these service reductions. Indeed, research evidence indicates that older women are more likely to be institutionalized than older men (Shapiro and Tate, 1988; Wilkins and Park, 1998)

The implications of this are that those women who do not have informal social networks available to them, or who are unable to afford to access privately paid for care are at risk of having their care needs go unmet (Chen and Wilkins, 1998) and are placed at greater risk of institutionalization (Chen and Wilkins, 1998; Wilkins and Park, 1998). Indeed, research indicates that older women are more likely to be institutionalized than are older men (Norris et al., 1999; Shapiro and Tate, 1988)

There is also evidence that supports arguments that in-home care services are being disproportionately targeted to those with comparatively high levels of care need (Baranek, Deber and Williams, 1999; Segall and Chappell, 2000). Findings indicate that those with high levels of care needs, who may be better served through other forms of care (such as hospital or long term institutional care), may be receiving a greater proportion of services allocated to those living in the community.

The original mandate of the Continuing Care Act was to support adults who have needs arising from a long-term health related condition. However, findings here indicate that those with comparatively high levels of physical disability in relation to instrumental activities of daily living are more likely to receive care services than those with lower levels of care needs, and that among those who receive in-home care services, those with high levels of disability associated with basic activities of daily living receive a greater number of in-home care hours. These findings imply that there has not been a shift in the philosophy of care from an emphasis on medical interventions to community level care focusing on prevention and promotion as recommended by the Seaton Commission (1991), but rather a shift in venue. As was noted earlier, prior research in British Columbia has found that although funding for in-home care services increased immediately following the Seaton Commission's recommendations, funding levels have declined in recent years (Segal and Chappell, 2000). Not surprisingly given the reductions in funding, the number of clients served by the continuing care program has also decreased. Given the financial constraints placed on the continuing care system and the reductions in hospital stays, it may not be surprising that services are targeted to only those with the greatest levels of care needs. However, it is important to note that the findings presented here are hardly conclusive.

Nevertheless, in applying a political economy perspective which emphasizes state-market relations to these results, the implication of in-home care services being targeted to those with care needs which may be better served through other forms of care, is that continuing care services may be used as a vehicle to de-insure services once covered under the Canada Health Act, rather than to promote health and independence in order to meet the demands of the market.

Researchers applying a critical perspective on the role of the state and an aging population have argued that a consequence of globalization and adoption of neoliberal ideologies to meet the interests of capital has resulted in a shifting of responsibilities in relation to health care from the public sector to the private (Aronson. 1998; Keating et al., 1997). Although this study did not employ the use of longitudinal data, and cannot speak to whether or not a shift has occurred, findings from this study offer support to the claim

that informal social networks play a role in the ability of older adults to access in-home care services.

Consistent with prior research indicating that those with the greatest levels of informal support are the least likely to access formal care services (Chen and Wilkins, 1998; Mutchler and Bullers, 1994; Wilkins and Beaudet, 2000; Wilkins and Park, 1998), this study found that as the number of family members respondents reported knowing increased, the expected probability of receiving home care services decreased. Further, findings presented here indicated that those with higher levels of ADL disability are also less likely to receive service among community dwelling older adults.

Given these findings, we may conclude that family members do play an important role in providing care to older adults, particularly those with very high levels of health-related care needs. Although it is often assumed that 'family care is the best care': "research suggests that, given alternatives, elderly people do not want to rely on the care of family" (Aronson and Neysmith, 1997, p. 45). This assertion is reinforced by Newsom and Schultz (1998) who found that "Some (informal) care recipients have also reported lowered self-esteem in response to help, feelings of rejection, feelings of dependency, anger, resentment, concerns about reciprocity and feelings of incompetence" (p. 183). Thus, although family often provides seniors with much needed assistance; formal care services may provide a greater sense of independence and autonomy, leading to higher levels of life satisfaction. Further, as noted earlier, Glazer (1990) and Guberman and Maheu (1999) have argued that informal care providers may be unable to appropriate care to those with intense or high levels of care needs, placing the health of the recipient of care at risk.

A political economy approach also recognizes that the potential costs of unpaid caring will unfold differently for both men and women in different social locations. As noted earlier, those with greater resources, by virtue of class, will be better equipped to absorb or offset the costs associated with caring, either by accessing care privately or through benefits and entitlements, such as private insurance, accumulated through the formal economy.

Further, given that women are more likely to be both the primary recipients of care as well as care providers, home care policy that relies heavily on informal care

providers to fill the gaps, will have a particularly negative impact upon women (Evans and Werkele, 1997). Indeed, feminists applying a political economy approach have argued that the rationale for cuts to particular social welfare programs such as home care services is located in a neoliberal ideology of personal and familial responsibility in order to meet the demands of capital and the state and are the result of power relations and traditional gender roles (McDaniel, 2003). Thus, in the process of relying on informal care providers and reducing or limiting in-home care services, the welfare state may be creating or maintaining inequality among men and women, and those of varying class statuses (Armstrong, 2001; Estes, 1991, 1999; McDaniel, 2002; Norris, 1999).

Additionally, in applying a political economy approach to these findings, it may be argued that the conceptualization of old age as a period of absolute dependency, illness and functional decline, which is leading towards an economic crisis as the population ages, is misdirected. The findings presented here indicating that age is not a predictor of physical limitations associated with basic activities of daily living, may lead us to conclude that age is not a predictor of severe functional disability. Indeed, Evans et al. (2001) argue that although increasing costs associated with health care are often attributed to population aging, older adults as a whole are healthier now than they were forty years ago, and consequently experience less severe forms of illness. As a result, it is not intense medical interventions that are required (typically the most expensive), but rather less expensive forms of care and treatment (Evans et al., 2001; Penning, 2002; Wilkins and Park, 1996). While age may be associated with physical decline, the health-related needs of older adults often stem from illnesses that require long-term care services rather than medical interventions. Thus, although age may be associated with functional limitations and decline associated with age related illness such as arthritis (the most common form of illness in old age according to Wilkins and Park, 1996), and these types of disabilities may limit the ability of some older adults to live independently in their homes, home care services provide a cost effective means of promoting health and independence.

Evans et al (2001) argue that the crisis of an aging population is perpetuated to serve the interests of the state in reducing social welfare programs in order to meet the demands of capital, as well as the existing medical industrial complex composed of

health care workers whose incomes are dependent on the continued support of the medical model. "Every dollar of expenditures is a dollar of someone's income, and a claim that expenditures must rise dramatically to meet rapidly increasing needs is simultaneously a demand for a larger pool of incomes for providers of care" (Evans et al, 2001, p. 187). Thus, this 'crisis' is upheld to support the existing health care structure. The consequence of supporting this claim is that it enables the welfare state to reduce funding directed at health care as it is seen as no longer sustainable (Evans et al., 2001).

Finally, in applying a political economy perspective to the examination of accessibility to in-home care services in British Columbia, attention must be given to intersections of gender and class. Although interaction terms between gender and class, and gender and income were tested for each model, none of the interactions proved to be significant. This may be attributed to problems associated with the class variable, the homogonous nature of respondents in relation to reported income, or to the fact that class status and gender or income and gender are simply not accurate predictors of the type or extent of care received among those in this sample.

Despite the absence of findings in relation to the intersections of class and gender, the results presented here do not necessarily indicate that a political economy approach is invalid theoretical tool. The primary purpose for the use of a political economy approach in this study was not to prove or disprove the validity of the theory itself. Rather, it served as a lens through which we may see the social world in order to inform the questions asked and guide the interpretation of findings. Thus, although this study did not find that intersections of gender and class were predictors of type or extent of care received or paid for, the application of a political economy approach was useful in examining the main effects of class and gender and accessibility to home care services. However, further theorizing is needed to fully understand the potential implications of class and gender relations throughout old age, and additional investigation which applies this type of approach is needed in order to authoritatively conclude that these findings are indeed representative of the current situation in British Columbia.

6.3 Limitations of the Study

There are several limitations associated with the nature of the data themselves and the types of analyses used in the study that must be considered when interpreting findings.

The first consideration that must be taken into account is the cross-sectional nature of the data. Typically, researchers applying a political economy framework tend to rely on historical or comparative analyses. The use of longitudinal data is generally seen as preferable as it allows for a more thorough examination of the impact of public policy changes that occur over time. Similarly, comparative analyses allow for a more explicit examination of how the shaping of public policy, such as eligibility criteria, impacts upon access to care services. Given that these data were not longitudinal and did not vary in location, this limited the ability of the study to examine how access to in-home care services may have changed over time in response to budget constraints or policy shifts. As noted earlier, these data were collected immediately after a series of budget cuts and service reductions that saw a review of all clients receiving weekly housekeeping services and the termination of home support services to 72% or 1,932 of the 2,674 clients reviewed (Chappell and Penning, 1996, p. 9). Had data been collected both before and after these service reductions, it may have been possible to support the argument that reductions of services have disproportionately affected those of lower class status and women.

Further, given that the data were collected solely in the Capital Regional District of British Columbia, comparative analyses among provinces or regions, which may have allowed for stronger conclusions surrounding the effects of criteria such as health status, income requirements and the role of informal social networks in accessing care were not possible. For example, had the data been collected in Manitoba, which does not implement income testing as well as British Columbia, which does implement income testing, more meaningful conclusions may have been made surrounding the impact of income testing on access to in-home care services among an older population.

Although these data did address questions surrounding in-home care utilization within both the private and public sectors, as is often the case with secondary data, the nature and type of questions did not necessarily address important elements that were the focus of this study. Although findings revealed that there were differences associated with health-related need, marital status and in some cases gender in relation to the type of care received, as well as determining difference in relation to access to publicly subsidized care services, it did not address whether these services met the care needs of respondents. Thus, the results surrounding the adequacy of publicly subsidized care are necessarily limited given this omission.

Although one of the strengths of these data is that it provided information on both those who were users of publicly subsidized in-home care, as well as older adults living in the community who experienced functional limitations and did not receive publicly subsidized in-home care services, sampling procedures and the overall sample size may limit the generalizability of these results. What makes these data useful in examining characteristics of those who receive services as compared to those who do not, also limits its generalizability as the survey is not considered representative of the general population of older adults, but more closely represents those who are characterized by a high level of need. Further, the results of this analysis are not generalizable to a larger population given eligibility criteria and service provision itself varies from province to province, making it impossible to draw conclusions that may be applied outside of the Capital Regional Health District.

As noted earlier, the initial sample consisted of 1,012 older adults-506 users and 506 non-users of publicly funded home support services. Participants were matched by age, gender and functional health status. In order to match participants according to functional health status, two groups were created: 1) those who reported no ADL limitations and 2) those who reported any degree of ADL impairment. Those who reported no functional impairment with activities of daily living were matched based on ability to perform instrumental activities of daily living. The use of such a global measure of disability may be problematic. Although the sample is matched based on the fact that all participants experienced some form of ADL or IADL limitation, non-service users were selected and matched with a service user if they experienced one or more physical

limitations based on ADL or IADL measures. However, those who received publicly subsidized care may have experienced a greater number of health limitations, or comparatively more severe limitations in their ability to function independently than those who did not receive service.

Further, sampling methods that matched service users and non-service users based on gender, age and health status may have also limited variability in relation to health, gender, income and ethnicity. Given that service users are characterized as experiencing functional limitations associated with health need, and the sample was matched based on health need as one of the criteria for selection, this sample may not be said to represent all older adults in general. The same may be said of gender and age. Given that women are more likely to experience greater longevity and utilize home care services, women may also have been over represented in the sample. Further, we find that most respondents (82.6%) fell in the middle two income groups, and there was very little variability in relation to ethnicity. Indeed, when asked about ethnic identification, 90% of respondents included in the survey reported their ethnicity as Canadian, Western or British. Consequently, the results presented here are not generalizable to the larger population.

In this study, the original construction of variables themselves may also be problematic. Although every effort was made to replicate, as closely as possible the measures of health status outlined in the LTC1, notably measures of ADL, IADL and the MMSE, these measures may not accurately parallel those used by case managers in determining eligibility. As seen in Appendix A, the LTC1 takes note of each physical limitation associated with basic and instrumental activities of daily living. However, it is not known if case managers give more weight to some forms of functional disability over others, or if they apply a global measure, as was done here, to measure overall functional ability.

Further, although informal care networks in the form of family, friends and neighbours were taken into consideration, these variables were based on respondents' reports of the number of friends, family members or neighbours they knew as opposed to the number of friends, family members or neighbours that provided them with some form of assistance. Given the ambiguity surrounding the role of informal social networks in the

assessment process, it is unclear how these relationships are considered during the assessment process.

Although previous studies have indicated that there are clear relationships between both occupational class and socioeconomic position in determining health status (Deonondan et al., 2000; Arber and Ginn, 1991; Arber and Evandrou, 1988; Cairney and Arnold, 1996; Glaser and Grundy, 2000; Krieger and Fee, 1994; Krieger, Williams and Moss, 1997; Manor et al., 1997; Wood et al., 1999), the findings reported here would suggest that there is no relationship. Although this may be attributed to the overall characteristics of the sample, it may also be a reflection of inaccurate measures, which would impact upon all models tested.

Although socioeconomic position has also been included in all analyses in order to allow for a fuller examination of class based differences (given the ambiguity surrounding the class status of homemakers), there are questions surrounding the diversity and consequently accuracy of the socioeconomic variable. Originally, the income variable was coded on a 24-point scale in response to the question "What is your average monthly household income?" with responses ranging from (1)"no income" to (24) monthly income of "$5,500 or more". Given the primacy afforded to income in this study, open ended questions surrounding income, and it's source may have allowed for a more accurate approximation of the income adequacy scale as constructed by Statistics Canada.

A further issue surrounding the income variable was the relatively large number of missing values (17.4%). Although these were replaced by the mean among service and non-service users, assumptions surrounding the actual income of these respondents may be inaccurate. Further, the majority of respondents (82.6%) reported incomes in the two middle-income categories (ranging from $14,988 to $60,000 or greater). Given the homogenous nature of the incomes of respondents (i.e., lack of variation in incomes), results surrounding the income variable may not provide accurate results surrounding income differences, which may have led to misleading or inaccurate results. Some of the problems with measures of income may have emerged as a result of the older adults who are being care for by others not knowing their actual income, or due to the original construction of the income variable. Finally, household income was used as the income

variable, which may result in an inaccurate representation of an individual's income, and consequently, their ability to meet the income test requirements. However, given that income adequacy levels are generally measured for both 1 and 2 person households, and the vast majority of participants did not live with more than one other person, the decision was made to apply household income at the individual level. Further, although only 6% of all respondents reported living with their adult children, had respondents reported their children's household income in addition to their own, this may skew the results.

As noted earlier, the measure of class may be problematic given the large proportion of homemakers that were included in the sample. The inclusion of the category of homemaker, although critical to this particular analysis, led to some ambiguous results. Given that we do not know the occupational class of the family of origin or the class status of the spouses of these women, we cannot be certain as to what their class status may be, or if the measure of homemakers, is in and of itself a representation of a distinct social class. As has been noted extensively, this application of class may be highly problematic when addressing older women (Arber and Ginn, 1991; Adler et al., 1994; Duncan, 2002; House et al., 1994; Krieger, Williams and Moss, 1997; Robert and House, 1996).

6.4 Contributions and Directions for Future Research

Despite these limitations, the results of this study represent an important addition to current research regarding public policy and in-home care services. Prior researchers have suggested that the crisis of old age in relation to old age is an inaccurate contention. To some degree, the findings presented here support this claim. Specifically, this study shows that while age may be a predictor of physical decline, it is not an accurate predictor of severe levels of disability, which require intense and expensive medical care. Thus, what is required is not more funding to uphold the current medical industrial complex, but rather, more funding directed to community level care that does address needs stemming from long-term chronic illness and functional decline.

In this regard, this study also provides some support to prior arguments that continuing care services in British Columbia are being disproportionately targeted to those with comparatively high levels of health-related need and that the government, in an effort to reduce costs, may be placing the onus of care which was once the responsibility of the public sector to the private. For those without informal care networks, or without financial resources available to access private care services, there is increased risk of having care needs go unmet.

Although this study did not find that class differences existed in relation to access to care, there is some support showing that women are less likely to receive in-home care services than are men, even when health status was controlled for. Although further research is required to duplicate and reinforce these findings, this study has potentially revealed that gender inequalities in relation to home care services do exist.

As noted extensively, the findings in this study surrounding privately accessed versus publicly provided care remain unclear. Although this study suggests that British Columbia's home care system relies on the private sector to provide care to older adults, a comparative analysis would allow for a more detailed examination of the impact of policy initiatives, such as income testing and needs assessments on access to care. While findings indicate that on a national level there are clearly persons being underserved (Chen and Wilkins, 1998), to date there has not been a comprehensive analysis of every province and accessibility to formal care services in relation to regional policy initiatives. "All provincial evaluations of their respective programs raise concerns about access to funding and organization of home care services but it is virtually impossible to discuss the issue comparatively" (Neysmith, 1995, p. 165). This absence is striking given the increased emphasis placed on home care to replace hospitalization or institutionalization in every province. Future research must address these issues comparatively in order to expose how different understandings of health and care and eligibility criteria impact upon an older population, and may create or maintain inequality.

Further, within the gerontological literature itself, intersections of gender and class remain under theorized. Although this study points to difference among men and women in terms of access to care in later life, and does take class into account, these differences remain explained as just that – difference. Numerous researchers have pointed that age

has been excluded from most 'mainstream' sociological theorizing (Arber and Ginn, 1991; Irwin, 1999; McMullin, 1995, 2000), and intersections of class, gender and age have been seriously neglected within the theoretical literature (Arber and Ginn, 1991; McMullin, 1995, 2000).

Clearly, further theorizing and research must be done in order to better understand how policy affects practice and quality of life among home care recipients, how access to support is influenced by gender differences, class and age, and what the long-term implications of these policy directions are on both a regional and national scale.

As the health-related needs of an aging population change, in-home care services become an increasingly important element of the formal health care system. In this regard, research must focus both on how our understandings of age are constructed and the implications of these understandings in the creation and implementation of social welfare policy so that inequalities may begin to be addressed.

6.5 Conclusions

This study has applied a political economy perspective to an examination of the accessibility of in-home care services in British Columbia, with particular attention given to gender and social class. Results of this study have produced findings which support arguments that the crisis of an aging population and the unsustainability of the health care system may be misguided, and that the welfare state, in an effort to reduce its costs, may be placing responsibility for care to the private sector. It has been argued that older adults, women and those of lower class status will be disproportionately affected by these changes. Further, findings suggest that home care policy in BC may contribute to unequal access to in-home care services along gender lines.

In light of the fact that there is increased emphasis on reducing the costs of health and health care, in-home care services and health promotion and prevention may play an increasingly important role in the formal health care system. With that in mind, our notions of health and illness must be expanded to include these types of services, and our understanding of age-related illness must be reshaped.

It has been suggested here and elsewhere, that a biomedical approach to health and illness does not reflect the health needs of many of many older adults (Aronson, 1998; Estes, 1991, 1999; Segall and Chappell, 2000). Further, there has been widespread acceptance of the recognition that nonmedical factors are powerful contributors to health status (Arber and Ginn, 1991; Aronson, 1998; Duncan, 2002; Estes, 1991, 1999; Navarro, 2002; Segall and Chappell, 2000). These developments lead us to question the disproportionate amount of attention given to medical interventions as the sole form of 'health care'. In light of these developments, policymakers must begin to focus not only on a reshaping of health care policy, but indeed, the role of all social welfare policy as integral in shaping the health of Canadians.

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APPENDIX A

Province of British Columbia
Ministry of Health and Ministry Responsible for Seniors
CONTINUING CARE PROGRAM

APPLICATION AND ASSESSMENT FORM

1 ☐ NEW ASSESSMENT
2 ☐ REVIEW
3 ☐ REASSESSMENT
4 ☐ APPEAL
5 ☐ CORRECTION

HEALTH DIST. | ASSESSOR | CLIENT NUMBER

SECTION 1 - ADMINISTRATIVE AND SUMMARY

CLIENT'S PERSONAL DATA

1 CLIENT'S FAMILY NAME | FIRST NAME | INIT'S. | PHONE (CURRENT)

2 LIST CLIENT'S ADDRESS FOR THE LAST 12 MONTHS. IF MORE THAN ONE, LIST ADDITIONAL ADDRESSES AND DATES IN PARA. F SUMMARY. ENSURE PRESENT LOCATION OF CLIENT IS REPORTED IN SPACE PROVIDED.

CURRENT ADDRESS | FROM (DATE)
CITY | POSTAL CODE
CURRENT LOCATION OF CLIENT: ☐ AS ABOVE ☐ OTHER

3. MARITAL STATUS
1 ☐ SINGLE
2 ☐ MARRIED
3 ☐ WIDOWED
4 ☐ DIVORCED
5 ☐ SEPARATED
6 ☐ OTHER

SEX ☐ M ☐ F | BIRTHDATE Y Y Y Y M M D D | PERSONAL HEALTH NUMBER | VETERAN SERVICE CATEGORY ☐ N If Yes ☐ A ☐ B ☐ U(Unknown) | SERVICE NUMBER

B

A CONTACT PERSON IS ONE WHO ASSISTS THE CLIENT WITH AN APPLICATION AND/OR A PERSON WHO IS WILLING TO MAINTAIN A CONTINUING INTEREST IN THE CLIENT'S WELFARE WITHOUT IMPLYING RESPONSIBILITY.

CONTACT PERSON'S FAMILY NAME | INIT'S. | RELATIONSHIP
STREET ADDRESS
CITY | POSTAL CODE | HOME PHONE | BUSINESS PHONE

C

GIVE DETAILS OF PERSON OR NEXT- OF- KIN WHO SHOULD BE CONTACTED IN AN EMERGENCY. ENTER CONTACT IF PERSON IS NAMED IN PARA. B

NAME | NEXT OF KIN ☐ YES ☐ NO | RELATIONSHIP | RESEARCH CODES
ADDRESS | POSTAL CODE

D

GIVE DETAILS OF PHYSICIAN RESPONSIBLE FOR CARE OF CLIENT. IF THERE IS A SPECIALIST OR OTHER PHYSICIAN ENTER IN PARA. F SUMMARY

PHYSICIAN'S NAME | OFFICE PHONE
OFFICE ADDRESS | POSTAL CODE

APPLICATION

I hereby apply for benefits for which I / Client may be eligible under the Continuing Care program and certify that the information I have provided is correct to the best of my knowledge and may be released to the Continuing Care provider.

X _____
Client or authorized signature

CLIENT'S PREFERENCE(SEE REVERSE) PREFERRED FACILITIES
1 ☐ AT HOME 2 ☐ FACILITY 21 ☐ STANDARD 22 ☐ SEMI-PRIVATE 23 ☐ PRIVATE

PREFERRED FACILITY | FACILITY CODE | DATE ON LIST YY MM DD
ALTERNATE FACILITY

CANADIAN CITIZEN ☐ YES ☐ NO | B.C. RESIDENT YY MM DD | BF CODE | BF DATE YY MM DD

F ASSESSMENT SUMMARY

1. ☐ NEW ASSESSMENT
2. ☐ REVIEW
3. ☐ REASSESSMENT

Y Y M M D D

LOCATION OF ASSESSMENT
1. ☐ HOME 2. ☐ FACILITY 3. ☐ HOSPITAL 4. ☐ OTHER

ACTION REQUIRED
1. ☐ TEAM REVIEW 2. ☐ FOLLOW-UP 3. ☐ NA

APPROVED SERVICES
1 ☐ NOT ELIGIBLE
2 ☐ CARE DECLINED BY CLIENT
3 ☐ CARE AT HOME
4 ☐ CARE AT HOME WITH MENTAL HEALTH SUPPORT
5 ☐ FACILITY CARE
6 ☐ DAY CARE

APPROVED CARE LEVEL
1 ☐ PC 4 ☐ IC 3
2 ☐ IC 1 5 ☐ EC
3 ☐ IC 2

LIVES WITH CARE GIVER ?
☐ YES ☐ NO

CASE MANAGER'S SIGNATURE: X | DATE:

G SERVICE AUTHORIZATION

PROVIDER ID	AUTHORIZATION DATE Y Y M M D D	SA - ID
☐ START	1 ☐ PAID 2 ☐ UNPAID	ORG. SERVICE TYPE
	CARE LEVEL CLIENT CONTRIBUTION $	APPROVED HRS./DAYS
☐ CHANGE	1 ☐ BEGIN PAID ABSENCE A ☐ VACATION B ☐ ILLNESS 2 ☐ RETURN	
☐ END	2 ☐ DEATH 5 ☐ UNPAID TEMP ABSENCE	
☐ CORRECT	☐ DELETE SA - ID	

AUTHORIZING SIGNATURE: | DATE:

PROVIDER ID	AUTHORIZATION DATE Y Y M M D D	SA - ID
☐ START	1 ☐ PAID 2 ☐ UNPAID	ORG. SERVICE TYPE
	CARE LEVEL CLIENT CONTRIBUTION $	APPROVED HRS./DAYS
☐ CHANGE	1 ☐ BEGIN PAID ABSENCE A ☐ VACATION B ☐ ILLNESS 2 ☐ RETURN	
☐ END	2 ☐ DEATH 5 ☐ UNPAID TEMP ABSENCE	
☐ CORRECT	☐ DELETE SA - ID	

AUTHORIZING SIGNATURE: | DATE:

[illegible]

These actions are minimum requirements for data entry.

A. CLIENT'S PERSONAL DATA

- most fields are self explanatory

A3 [illegible] appropriate [illegible] information can be obtained from Department of Veteran Affairs District Offices in Vancouver, Victoria, Prince George or Penticton.

A3 Check appropriate Marital Status. If situation is unusual, tick 5 (other) and describe circumstances in Section IVB1

C. RESEARCH CODES

Up to 3 Research Codes, determined by the Health Unit can be used to classify a client for future research.

E. APPLICATION AND CLIENT'S PREFERENCE

- When assessment is complete, have client sign application. If client cannot sign name, but can make his mark, assessor to enter name, the words "His/Her Mark" and countersign. If client cannot do either, signature of contact person will be acceptable as applying on behalf of the client.
- Assessor is to ensure that the client is aware he or she is specifically certifying that correct answers to Section IV A1, IV A2, IV A3 have been given.
- The client's preference should not be completed until after the assessment so that it is an informed choice. The client's condition and financial circumstances should be taken into consideration so that inappropriate choices are not indicated when premium payments are involved.
- Indicate Canadian Citizenship. Enter the date the client became a BC resident.
- Enter BF (bring forward) reason code and date, if applicable.

  BF codes: A=Referral B=Provider Request C=Review Plan or Hours D=Hospital to Community E=Awaiting Client Info F=Start Facility Services G=Other

F. ASSESSMENT SUMMARY

- Case Manager signs in the space provided and dates the signature.
- If the client lives with a caregiver in the client's own home (not a Family Care Home or Group Home) tick YES. A caregiver is defined as a family member or other person who provides ongoing care and/or supervision to a client.

G. SERVICE AUTHORIZATION (SA)

- Two services can be started/changed/ended in this section. Use the SA Action Memo to authorize additional starts/changes/ends to service.
- Continuing Care Manager or delegated person(s) signs in the Authorizing Signature space to authorize service.
- Once the SA information is entered into the computer, write the SA-ID in the SA-ID box.
- SAs will print on the Health Unit printer. Use the on-line 5OH screen to designate the printer, the number of copies and when SA's will print.

START OF SERVICE

- Authorization Date indicates when service can begin or the admission date.
- Paid or Unpaid indicates whether service is paid by the Continuing Care Division.
- Organization/Service/Type codes relate to the service provider's category. Use the on-line 6P7 screen to see available choices for a provider.
- For Homemaker Service or Day Care, indicate the approved hours or days and attach an authorized memo if in excess of normal limits. Also indicate client's contribution.

CHANGE TO SERVICE

- Authorization Date indicates when a change of service is to begin.
- For Homemaker Service or Day Care, indicate the approved hours or days and attach an authorized memo if in excess of normal limits. Indicate client's contribution, if changed.

TEMPORARY ABSENCE: (FACILITY CLIENTS ONLY)

Paid If the client has departed the facility on an approved paid temporary absence, indicate the Authorization Date in the Change Service section and tick a Vacation or Illness box. When the client returns from the approved paid absence, enter the date care resumes in a Change Service on an SA Action Memo and tick the Return box.

Unpaid If the client has left on an unpaid temporary absence, service must be terminated in the End Service section by ticking the Unpaid Temp Absence box. When the client returns from the unpaid absence, use the Start Service of an SA Action Memo.

END TO SERVICE

- Authorization date indicates when the service terminates.
- Tick the Death box or Unpaid Temp Absence box only if applicable. Blank indicates a normal end to service.

ERROR CORRECTIONS OR DELETIONS

- Tick the Correct or Delete box and indicate the Service Authorization being corrected or deleted.

ASSESSMENT PROFILE YY MM DD CLIENT FAMILY NAME CLIENT NUMBER 2

A. MEDICAL BACKGROUND 1 MAJOR MEDICAL PROBLEMS INCL PSYCHIATRIC DIAGNOSIS — INFO PROVIDED OR VERIFIED BY PHYSICIAN ☐ YES ☐ NO

2. MEDICATIONS	DOSAGE	FREQUENCY	ROUTE	PRESCRIBED BY

3. TREATMENTS/SPECIAL PROCEDURES

4. CLIENT SMOKES ☐ YES ☐ NO
DEGREE OF PROBLEM
☐ NONE ☐ MODERATE ☐ MAJOR

5. CLIENT DRINKS ☐ YES ☐ NO
DEGREE OF PROBLEM
☐ NONE ☐ MODERATE ☐ MAJOR

6. ALLERGIES _____

7. CURRENT DIET

EATING HABITS

HEIGHT: _____
WEIGHT: _____

B. MENTAL HEALTH - INDICATE WHICH OF THE FOLLOWING STATES ARE APPLICABLE FROM YOUR INTERVIEW TODAY: BASE ASSESSMENT ON WHAT YOU HAVE SEEN TODAY AND USE COLLABORATIVE INFORMATION AS REQUIRED.

1. ATTITUDE ☐ COOPERATIVE ☐ INDIFFERENT ☐ RESISTIVE ☐ DEMANDING ☐ SUSPICIOUS ☐ HOSTILE

2. APPEARANCE ☐ WELL GROOMED ☐ ADEQUATE ☐ DISHEVELLED ☐ INAPPROPRIATELY DRESSED ☐ ILL - NOT DRESSED

3. SELF DIRECTION ☐ INDEPENDENT ☐ NEEDS MOTIVATION ☐ NEEDS DIRECTION ☐ DEPENDENT

4. BEHAVIORS ☐ NORMAL ☐ WANDERING ☐ SUNDOWNING ☐ WITHDRAWN ☐ SEXUALLY INAPPROPRIATE ☐ RESTLESS ☐ ELOPING ☐ SELF DESTRUCTIVE ☐ FIRE HAZARD ☐ OTHER (SPECIFY BELOW) AGGRESSIVE: VERBAL ☐ PHYSICAL ☐

5. AFFECT ☐ APPROPRIATE ☐ ANXIOUS ☐ EUPHORIC ☐ LABILE ☐ HISTORY OF MOOD SWINGS ☐ INAPPROPRIATE ☐ BLUNTED ☐ DEPRESSED ☐ ANGRY _____

6. THOUGHT CONTENT ☐ NORMAL DELUSIONS: ☐ PERSECUTORY ☐ GUILT ☐ OTHER ☐ OBSESSIONS ☐ PHOBIAS ☐ PREOCCUPATION ☐ NOT ABLE TO ASSESS

7. PERCEPTIONS ☐ NORMAL HALLUCINATIONS: ☐ AUDITORY ☐ VISUAL ☐ OTHER _____

8. COGNITION ☐ NORMAL IMPAIRMENT: ☐ MILD ☐ MODERATE ☐ SEVERE MINI MENTAL STATUS SCORE _____ EXPLAIN REASON FOR NOT COMPLETING

9. INSIGHT ☐ GOOD ☐ PARTIAL ☐ NONE

10. JUDGEMENT ☐ GOOD ☐ ADEQUATE ☐ POOR

C. ADDITIONAL COMMENTS:

LONG TERM CARE ASSESSMENT — SECTION II CONTINUED — HEALTH PROFILE | DATE | CLIENT FAMILY NAME | CLIENT NUMBER | 3

D DENTAL CARE

1 DOES CLIENT CURRENTLY HAVE DENTAL PROBLEMS? YES / NO

IS CLIENT UNDER CARE OF DENTIST? YES / NO

3 DENTAL STATE
1 NO DENTURES
2 FULL UPPER
3 FULL LOWER
4 PARTIAL DENTURE
5 DAMAGED DENTURE
6 NO DENTURES, NO TEETH
7 DENTURES NOT WORN

4 IS CLIENT ABLE TO CHEW FOOD EFFICIENTLY? YES / NO

5 DENTIST'S NAME

E COMMUNICATION

1 WEARS GLASSES 2 USES HEARING AID

LANGUAGES USED: 1 ENGLISH 2 FRENCH 3 CHINESE 4 ITALIAN 5 RUSSIAN 6

1 VISION	1 UNIMPAIRED	2 ADEQUATE FOR PERSONAL SAFETY	3 DISTINGUISHES ONLY LIGHT OR DARK	4 BLIND SAFE IN FAMILIAR LOCALE	5 BLIND REQUIRES ASSISTANCE
2 HEARING	1 UNIMPAIRED	2 MILD IMPAIRMENT	3 MODERATE IMPAIRMENT BUT ADEQUATE FOR SAFETY	4 IMPAIRED — INADEQUATE FOR SAFETY	5 TOTALLY DEAF
3 SPEECH	1 UNIMPAIRED	2 SIMPLE PHRASES INTELLIGIBLE ONLY	3 SIMPLE PHRASES PARTIALLY INTELLIGIBLE ONLY	4 ISOLATED WORDS INTELLIGIBLE ONLY	5 NO SPEECH OR SPEECH NOT UNDERSTANDABLE OR NO SENSE MADE
4 UNDERSTANDING	1 UNIMPAIRED	2 UNDERSTANDS SIMPLE PHRASES ONLY	3 UNDERSTANDS KEY WORDS ONLY	4 UNDERSTANDING UNKNOWN	5 NOT RESPONSIVE
5 IF CLIENT CANNOT SPEAK INDICATE MEANS AND DEGREE OF EFFECTIVENESS OF METHOD	1 EFFECTIVE	2 MODERATELY EFFECTIVE	3 PARTIALLY EFFECTIVE	4 NOT EFFECTIVE	

6 ADDITIONAL COMMENTS ON COMMUNICATION

F ACTIVITIES OF DAILY LIVING

1 USES CANE 2 USES WALKER 3 USES CRUTCHES 4 USES WHEELCHAIR 5 OTHER PROSTHESIS OR AID

1 AMBULATION	1 INDEPENDENT IN NORMAL ENVIRONMENTS	2 INDEPENDENT ONLY IN ENVIRONMENT SPECIFIED BELOW	3 REQUIRES SUPERVISION	4 REQUIRES OCCASIONAL OR MINOR ASSISTANCE	5 REQUIRES SIGNIFICANT OR CONTINUED ASSISTANCE
LIMITATIONS:					
2 TRANSFER	1 INDEPENDENT	2 SUPERVISION FOR: BED, CHAIR, TOILET	3 INTERMITTENT ASSIST: BED, CHAIR, TOILET	4 CONTINUED ASSIST: BED, CHAIR, TOILET	5 COMPLETELY DEPENDENT FOR ALL MOVEMENT
3 BATHING	1 INDEPENDENT IN BATH OR SHOWER	2 INDEPENDENT WITH MECHANICAL AIDS	3 REQUIRES MINOR ASSISTANCE OR SUPERVISION	4 REQUIRES CONTINUED ASSISTANCE	5 RESISTS
4 DRESSING	1 INDEPENDENT	2 SUPERVISION AND/OR CHOOSING OF CLOTHING	3 PERIODIC OR DAILY PARTIAL HELP	4 MUST BE DRESSED	5 RESISTS
5 GROOMING/HYGIENE	1 INDEPENDENT	2 REQUIRES REMINDER MOTIVATION AND/OR DIRECTION	3 REQUIRES ASSIST WITH SOME ITEMS	4 REQUIRES TOTAL ASSISTANCE	5 RESISTS
6 EATING	1 INDEPENDENT	2 INDEPENDENT WITH SPECIAL PROVISION FOR DISABILITY	3 REQUIRES INTERMITTENT HELP	4 MUST BE FED	5 RESISTS
7 BLADDER CONTROL	1 TOTALLY CONTINENT	2 ROUTINE TOILETING OR REMINDER	3 INCONTINENCE DUE TO IDENTIFIABLE FACTORS	4 INCONTINENT — LESS THAN ONCE PER DAY	5 INCONTINENT — MORE THAN ONCE PER DAY
8 BOWEL CONTROL	1 TOTALLY CONTINENT	2 ROUTINE TOILETING OR REMINDER	3 INCONTINENCE DUE TO IDENTIFIABLE FACTORS	4 INCONTINENT — LESS THAN ONCE PER DAY	5 INCONTINENT — MORE THAN ONCE PER DAY

9 ADDITIONAL REMARKS ON ADL: NOTE FREQUENCY OF GROSS PROBLEMS; COMMENT ON SIGNIFICANT SLEEP PATTERNS

LONG TERM CARE SECTION III SOCIAL
ASSESSMENT PROFILE

CLIENT FAMILY NAME | CLIENT NUMBER | 4

A HOUSING AND SOCIAL CONTEXT

1 HOUSING — APPROPRIATENESS

MODE

1 ☐ HOUSE
2 ☐ APARTMENT
3 ☐ ROOM
4 ☐ FACILITY
5 ☐ OTHER

1 ☐ RENTAL 2 ☐ SELF-OWNED 1 ☐ CURRENT 2 ☐ PROPOSED

2 HOUSEHOLD COMPOSITION — DESCRIBE RELATIONSHIPS

COMPANIONS

1 ☐ LIVES ALONE
2 ☐ SPOUSE
3 ☐ OTHER ADULT MALE(S)
4 ☐ OTHER ADULT FEMALE(S)
5 ☐ CHILDREN
GIVE AGES

PRINCIPAL HELPER

3 SUPPORTIVE RELATIONSHIPS (SEE GUIDE ON REVERSE OF THIS PAGE)

4 RELEVANT CULTURAL AND RELIGIOUS FACTORS

B SELF CARE INDICATE CLIENT'S CAPABILITY ON MOST DAYS

1 FOOD PREPARATION	2 ☐ ADEQUATE IF INGREDIENTS SUPPLIED	3 ☐ CAN MAKE OR BUY MEALS BUT DIET INADEQUATE	4 ☐ PHYSICALLY OR MENTALLY UNABLE	5 ☐ NO OPPORTUNITY OR DOES NOT PARTICIPATE BY CHOICE
1 ☐ INDEPENDENT				
2 HOUSEKEEPING	2 ☐ CAN PERFORM ONLY LIGHT TASKS ADEQUATELY	3 ☐ PERFORMS LIGHT TASKS BUT NOT ADEQUATELY	4 ☐ NEEDS REGULAR HELP AND SUPERVISION	5 ☐ NO OPPORTUNITY OR DOES NOT PARTICIPATE BY CHOICE
1 ☐ INDEPENDENT WITH HELP FOR HEAVY TASKS				
3 SHOPPING	2 ☐ INDEPENDENT ONLY FOR SMALL ITEMS	3 ☐ MUST BE ACCOMPANIED	4 ☐ PHYSICALLY OR MENTALLY UNABLE	5 ☐ NO OPPORTUNITY OR DOES NOT PARTICIPATE BY CHOICE
1 ☐ INDEPENDENT				
4 TRAVELLING	2 ☐ NO PUBLIC TRANSPORT USES PRIVATE VEHICLE OR TAXI	3 ☐ CAN TRAVEL ONLY IF ACCOMPANIED	4 ☐ PHYSICALLY OR MENTALLY UNABLE	5 ☐ REQUIRES AMBULANCE FACILITIES
1 ☐ INDEPENDENT				
5 TELEPHONE	2 ☐ DIALS WELL KNOWN NUMBERS	3 ☐ ANSWERS TELEPHONE ONLY	4 ☐ PHYSICALLY OR MENTALLY UNABLE	5 ☐ NO OPPORTUNITY OR DOES NOT USE PHONE
1 ☐ INDEPENDENT				
6 MEDICATIONS AND TREATMENTS	2 ☐ REQUIRES REMINDER OR ASSISTANCE	3 ☐ RESPONSIBLE IF MEDICATIONS PRE—PARED IN ADVANCE	4 ☐ PHYSICALLY OR MENTALLY UNABLE	5 ☐ RESISTS
1 ☐ COMPLETELY RESPONSIBLE FOR SELF				

7 COMMENTS ON SELF CARE

C SERVICE INVENTORY - SEE GUIDE ON INSTRUCTION PAGE

CODE	HEALTH SERVICES	Y/N	CODE	HOME SUPPORT SERVICES	N/Y	CODE	COMMUNITY SERVICES	N/Y
	☐			☐			☐	
	☐			☐			☐	
	☐			☐			☐	
	☐			☐			☐	
	☐			☐			☐	
	☐			☐			☐	

LONG TERM CARE ASSESSMENT 5 ☐ CORRECTION — SECTION IV SERVICE RECOMMENDATIONS

A FINANCIAL AFFAIRS

1 DOES CLIENT RECEIVE "GAIN FOR SENIORS" OR "GAIN" FOR HANDICAPPED"?
1 ☐ YES
2 ☐ NO
IF YES ➡

IF CLIENT IS 65 YEARS OF AGE OR OLDER, RECORD THE 9 DIGIT NUMBER WHICH APPEARS TO THE RIGHT OF THE PAYEE'S NAME ON THE "GAIN" CHEQUE.

IF THE CLIENT IS UNDER 65 YEARS OF AGE, RECORD ALSO ANY ALPHABETIC SUFFIX AFTER THE 9 DIGIT NUMBER.
IF NUMBER IS LESS THAN 9 DIGITS, ZERO-FILL FROM LEFT

START 9 DIGIT NO. HERE

PLACE ANY ALPHABETIC SUFFIX HERE

2 IS THE CLIENT IN RECEIPT OF THE GUARANTEED INCOME SUPPLEMENT?
1 ☐ YES
2 ☐ NO

3 IS THE CLIENT IN RECEIPT OF WAR VETERANS ALLOWANCE?
1 ☐ YES
2 ☐ NO

4 IF ANSWER TO 1, 2, 3 IS "NO", IS THERE AN INDICATION OF FINANCIAL NEED FOR FACILITY PER DIEM AND PERSONAL NEEDS?
1 ☐ YES
2 ☐ NO

5 IS THE CLIENT IN RECEIPT OF THE OLD AGE SECURITY PENSION?
1. ☐ YES
2. ☐ NO

6 IF ANSWER TO 5 IS "YES" AND THE CLIENT IS MARRIED, WILL CLIENT BE ELIGIBLE FOR A SINGLE PERSON'S OAS PENSION RATE ON FACILITY ADMISSION?
1. ☐ YES
2. ☐ NO
3. ☐ N/A

7 IF ANSWER TO 6 IS "YES" AND FACILITY ADMISSION IS RECOMMENDED, HAS CLIENT BEEN ADVISED TO APPLY FOR THE SINGLE OAS PENSION RATE?
1. ☐ YES
2. ☐ NO
3. ☐ N/A

8 MANAGEMENT
1 ☐ INDEPENDENT IN ALL AFFAIRS
2 ☐ INDEPENDENT IF TRANSPORTED
3 ☐ NEEDS ADVICE WITH BANKING OR MAJOR PURCHASES
4 ☐ CAPABILITY OF COMPREHENSION DOUBTFUL
5 ☐ AFFAIRS MANAGED BY PUBLIC TRUSTEE, COMMITEE OR POWER OF ATTORNEY

9 WHO MANAGES AFFAIRS?
1 ☐ SELF
2 ☐ CONTACT
3 ☐ OTHER (STATE)

10 IS ARRANGEMENT IN PARA. 6 APPROPRIATE?
1 ☐ YES
2 ☐ NO

11 RESPONSIBILITY FOR COMFORTS.
1 ☐ SELF 2 ☐ CONTACT PERSON 3 ☐ OTHER: GIVE DETAILS BELOW

12 ADDITIONAL INFORMATION

B ASSESSOR'S COMMENTS AND RECOMMENDATIONS

COMMENTS ON CLIENT'S CURRENT SITUATION AND RECOMMENDATIONS FOR CARE OF CLIENT.

IF THE RESPONSE IN PARA. 3 BELOW IS CODE 5, MENTAL HEALTH ORIENTATION OF PROVIDER, DESCRIBE NATURE OF SPECIFIC PROBLEM.

3 RECOMMENDED OUTCOME
1 ☐ NOT ELIGIBLE
2 ☐ HOME MAKER
3 ☐ CARE IN FACILITY
4 ☐ HOME CARE PROGRAM
5 ☐ MENTAL HEALTH ORIENTATION OF PROVIDER
6 ☐ DAY CARE
1 ☐ PERSONAL CARE
2 ☐ INTERMEDIATE CARE 1
3 ☐ INTERMEDIATE CARE 2
4 ☐ INTERMEDIATE CARE 3
5 ☐ EXTENDED CARE

RECOMMENDED PROVIDER

RECOMMENDED HOURS OR SERVICES

G U I D E L I N E S

FOR THE ADMINISTRATION OF THE

MINI MENTAL STATE EXAMINATION

ON ASSESSMENT AND REASSESSMENT CONCERNING

LONG TERM CARE PROGRAM BENEFITS

PURPOSE

To assess an individual's mental functioning and ascertain his/her mental state if the individual's mental functioning is in doubt. The Mini Mental State Examination (MMSE) constitutes a valid tool for first assessments as well as reassessments and reviews. The MMSE also facilitates recording and documentation of longitudinal change.

BACKGROUND

An increasing number of people exhibit complex physical and psychological problems when they apply for Long Term Care Program (LTCP) benefits. The Mental Health Section of the LTCl form does not always depict the mental state of an individual accurately and exhaustively, and the administration of the MMSE is thought to enhance its explanatory power. The utility of the MMSE has been successfully tested through a comprehensive pilot project locally and similar studies elsewhere.

GUIDELINES

1.0 The MMSE may only be administered by assessors who have been trained in its use.

1.1 Continuing Care Administrators (CCA) or Long Term Care Administrators (LTCA) must ensure that the MMSE is administered only by qualified staff.

1.2 The Continuing Care Division (CCD) and CCA's or LTCA's must ensure documentation of staff who have received training in the use of the MMSE.

. . . 2

2.0 The MMSE shall be administered to all clients on initial assessment, subject to the following exceptions:

2.1 Client has significant physical or sensory handicap, such as hearing or speech disabilities or loss of vocal cords.

2.2 Client displays significant lack of communication skills. Does not speak English and can not read or write.

2.3 Client has significant psychiatric or cognitive impairment that precludes completion of the MMSE.

2.4 Client is anxious, hostile, and refuses examination. The MMSE may be administered at a future assessment.

2.5 Client is receiving palliative care.

2.6 Client is obviously able to reason.

3.0 Administration of the MMSE on reassessment is at the discretion of the assessor/case manager, who should be guided by:

3.1 Observable changes in the client's mental functioning.

3.2 Scores indicating need for continued reassessment.

3.3 Significant changes in behaviour such as withdrawal, bizarre mannerisms, delusions, violence, etcetera.

4.0 The MMSE is a confidential document, and, as such, the provisions of LTCP Policy 4.2.6, concerning confidentiality, are applicable.

Province of British Columbia

Ministry of Health
CONTINUING CARE DIVISION

THE FOLSTEIN MINI–MENTAL STATE EXAMINATION

Name: _____ Age: _____ D.O.B. _____

Place Seen: _____ Date: _____

Ask Client his/her:

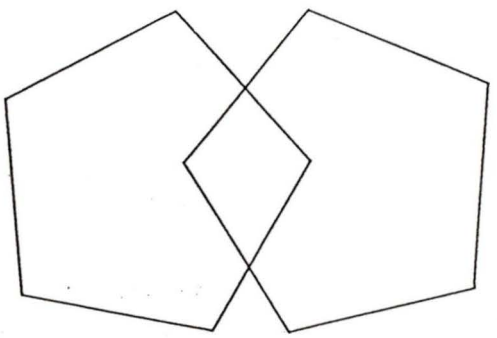
Name: _____ D.O.B. _____ Examiner: _____

	Maxium Correct Score	Client's Score	
			ORIENTATION
1)	5	( )	What is the – date _____, day of week _____, month _____, season _____, year _____?
2)	5	( )	Where are we – name of country _____, province _____, city _____, place _____, floor _____?
			REGISTRATION
3)	3	( )	Name 3 objects (HOUSE, TREE, CAR). Take 1 second to say each. Then ask the clientp all 3 after you have said them. Give 1 point for each correct answer. Then repeat them until he learns all 3. Count trials and record.
			TRIALS _____
			ATTENTION AND CALCULATION
4)	5	( )	Serial 7's 100 – 7 = ( ), 93 = ( ), 86 = ( ), 79 = ( ), 72 = ( ), 65. One point for each correct answer. (Alternatively spell "WORLD" backwards).
			RECALL
5)	3	( )	Ask for 3 objects – HOUSE ( ), TREE ( ), CAR ( )
			LANGUAGE
6)	9	( )	Name a pencil, and watch ( ) 2 points Repeat the following – "NO IFS, ANDS OR BUTS" ( ) 1 point Follow a 3 – stage command: "Take the paper in your right hand, fold it in half, and put it on the floor." ( ) 3 points Read and obey the following: CLOSE YOUR EYES ( ) 1 point

6) continued

Write a sentence (1 point)

Copy design (1 point)



_____ = **TOTAL SCORE**

Alert Drowsy Stupor Coma

Assess level of conciousness along a continuum, mark with an X

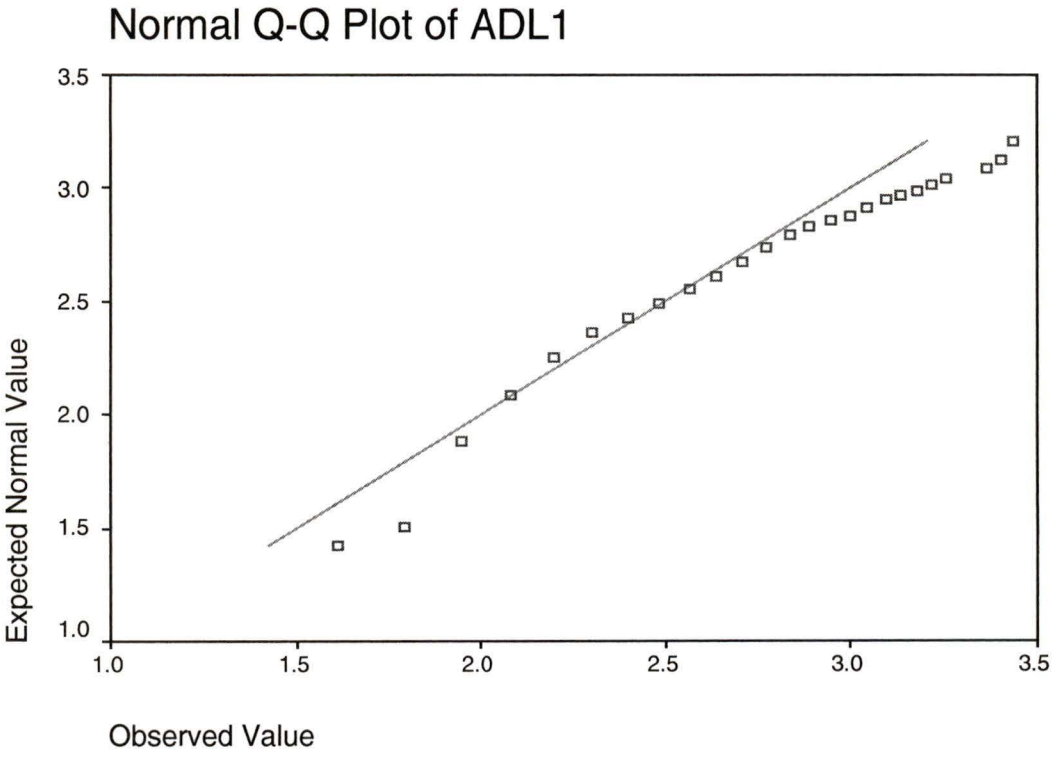
Have consent signed before examining

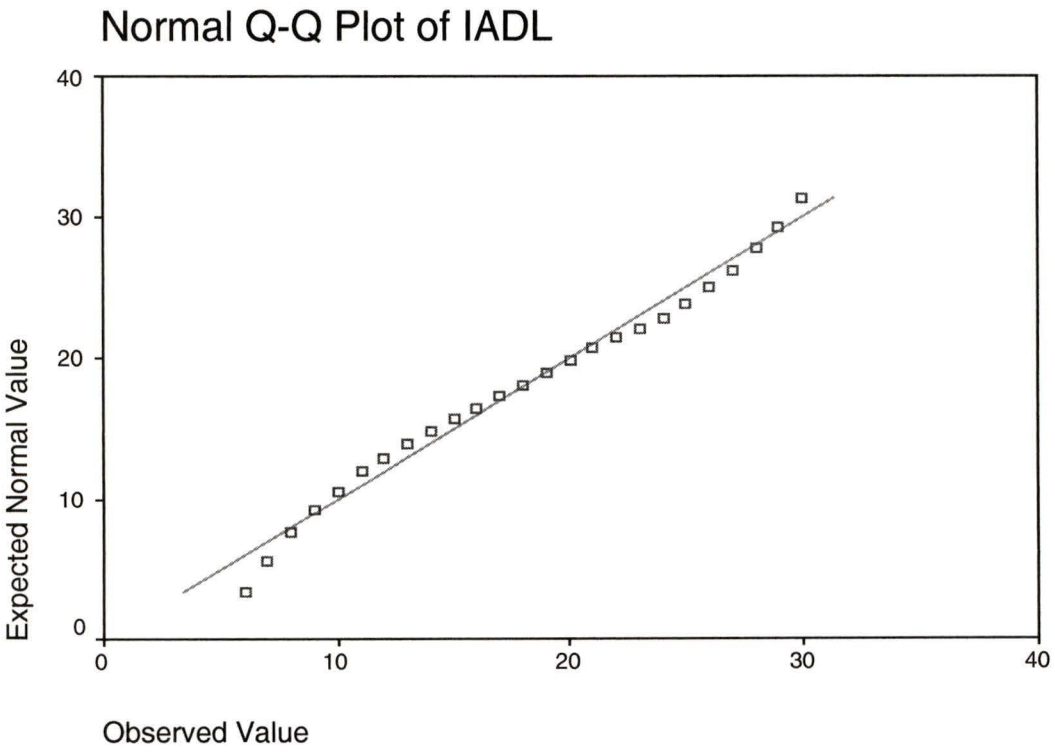
CLIENT CONSENT

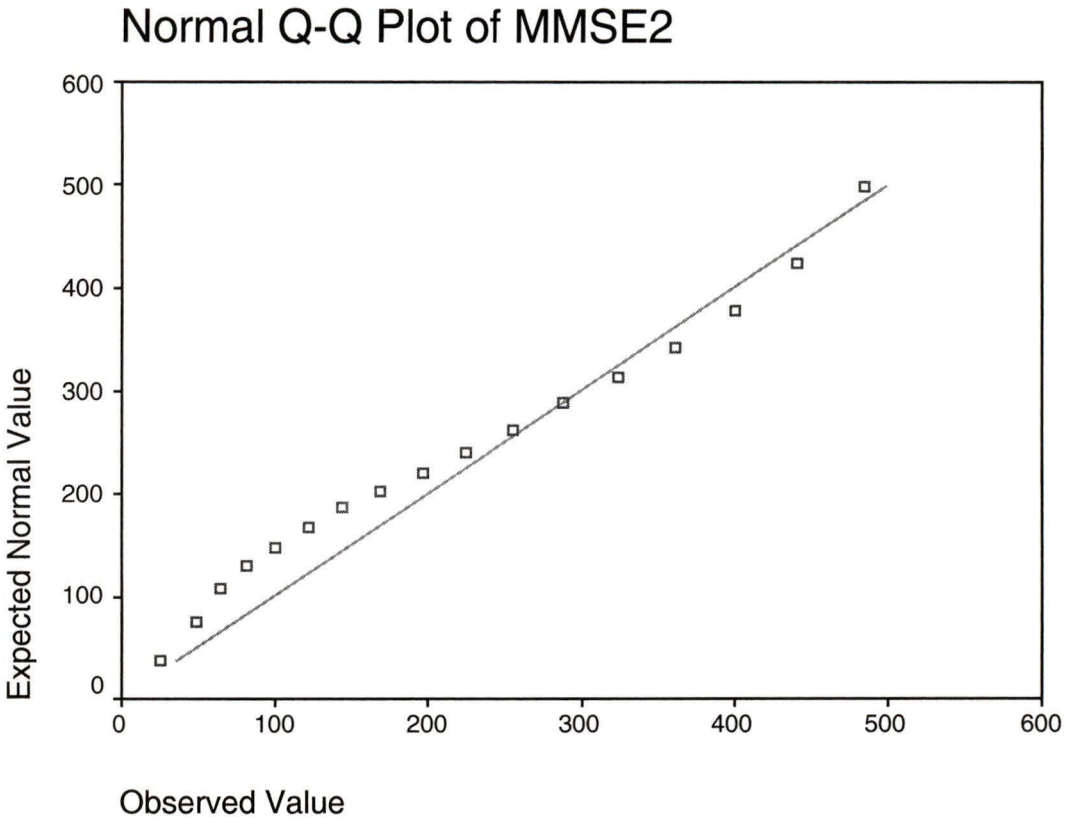
I understand that this examination explores my level of functioning and agree to take it as part of the standard assessment process.

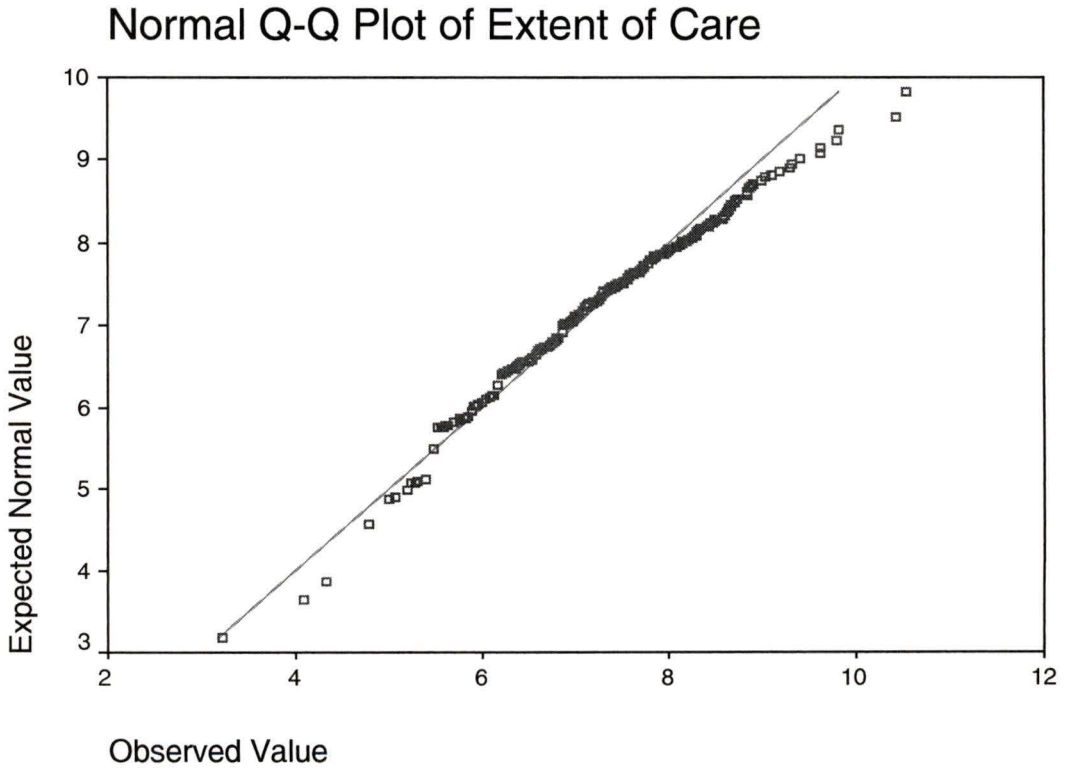
Date: _____ Signature: _____

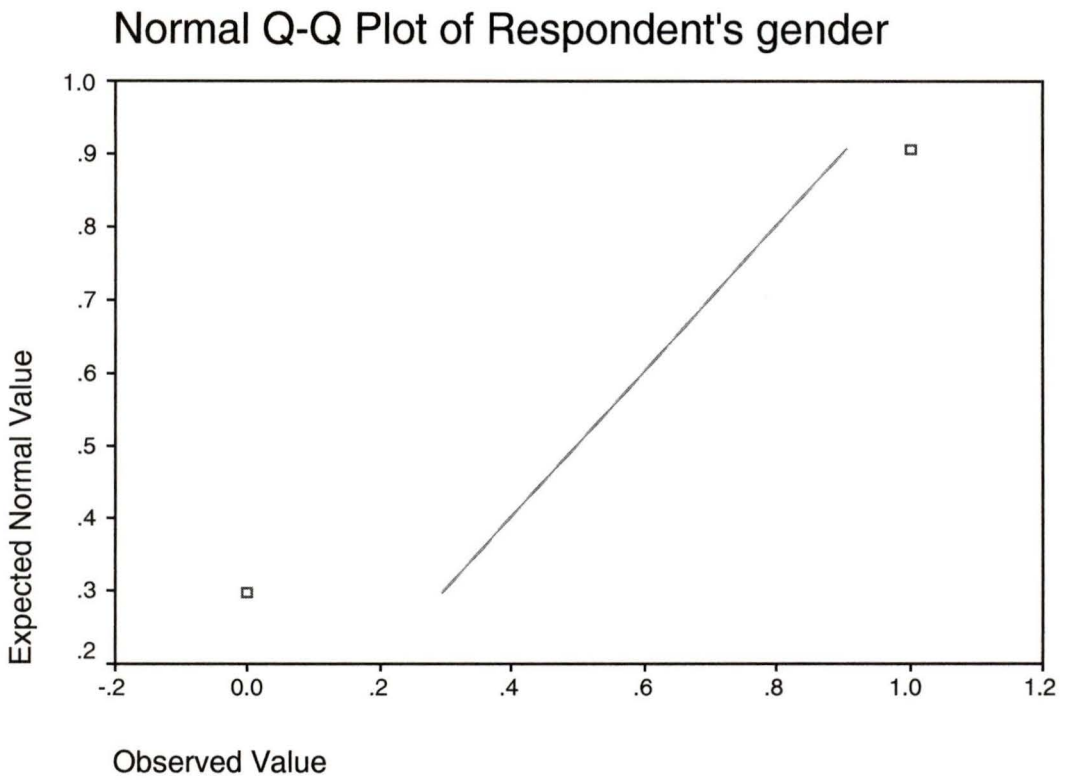
APPENDIX B

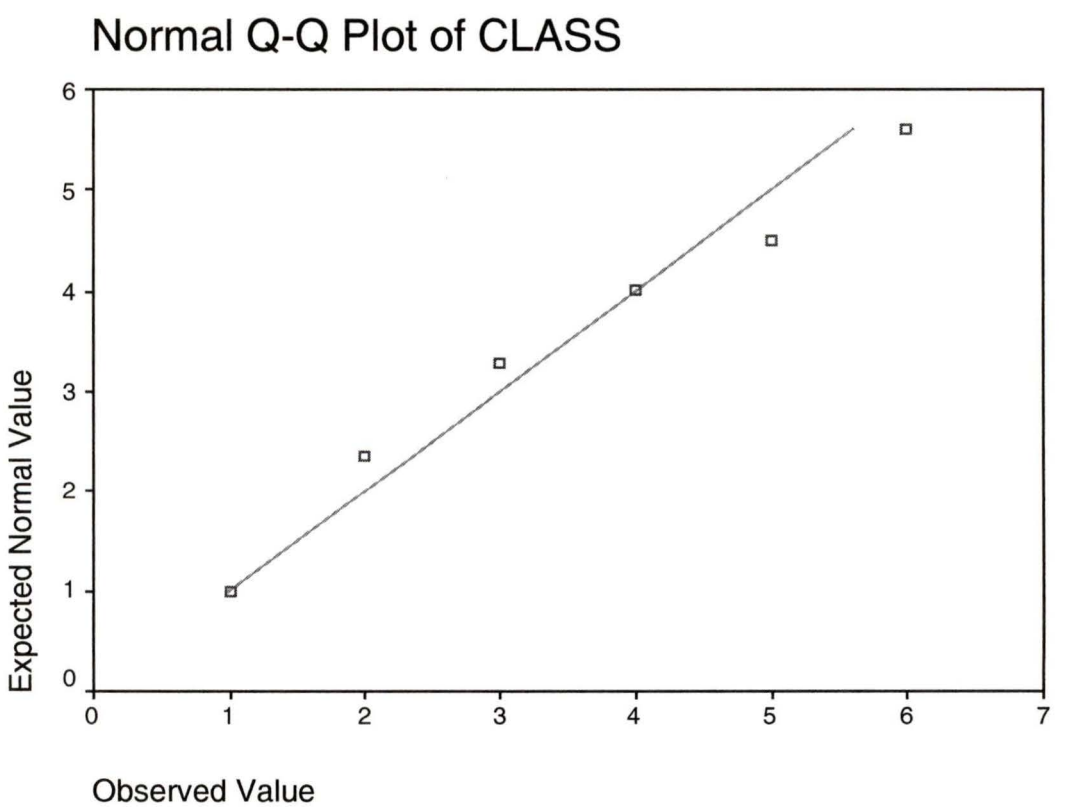

Normal Q-Q Plot of ADL1
Expected Normal Value
Observed Value
3.5
3.0
2.5
2.0
1.5
1.0
1.0
1.5
2.0
2.5
3.0
3.5

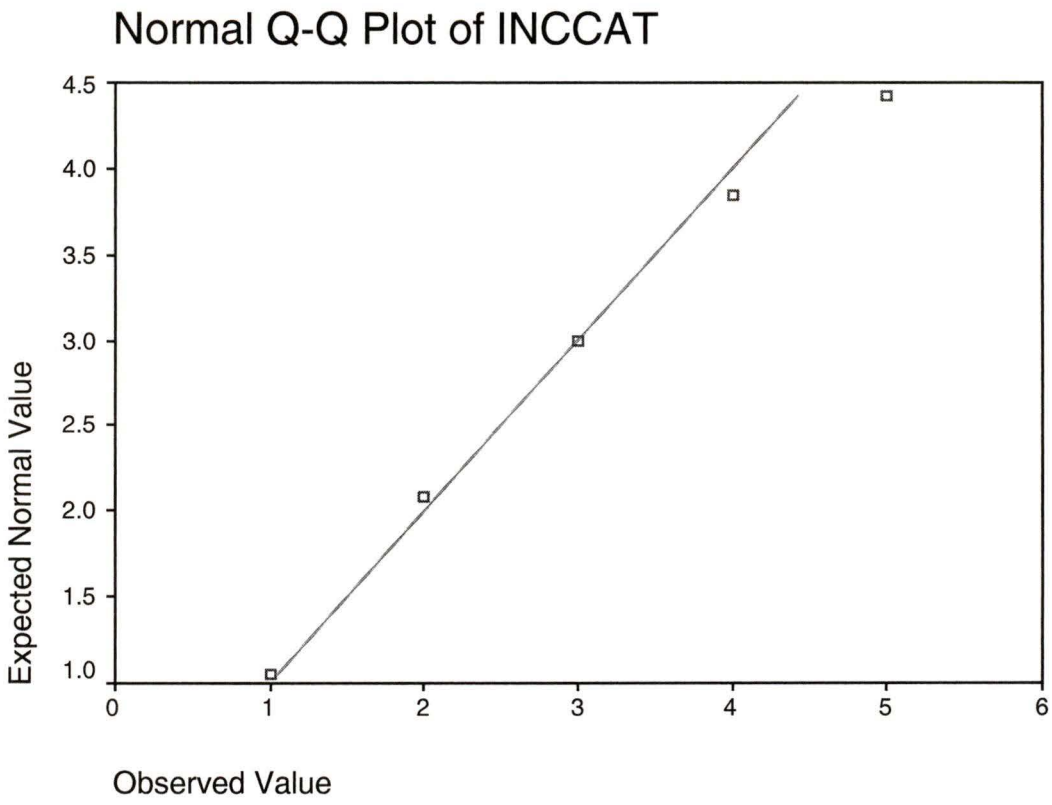

Normal Q-Q Plot of IADL
Expected Normal Value
Observed Value
40
30
20
10
0
0
10
20
30
40

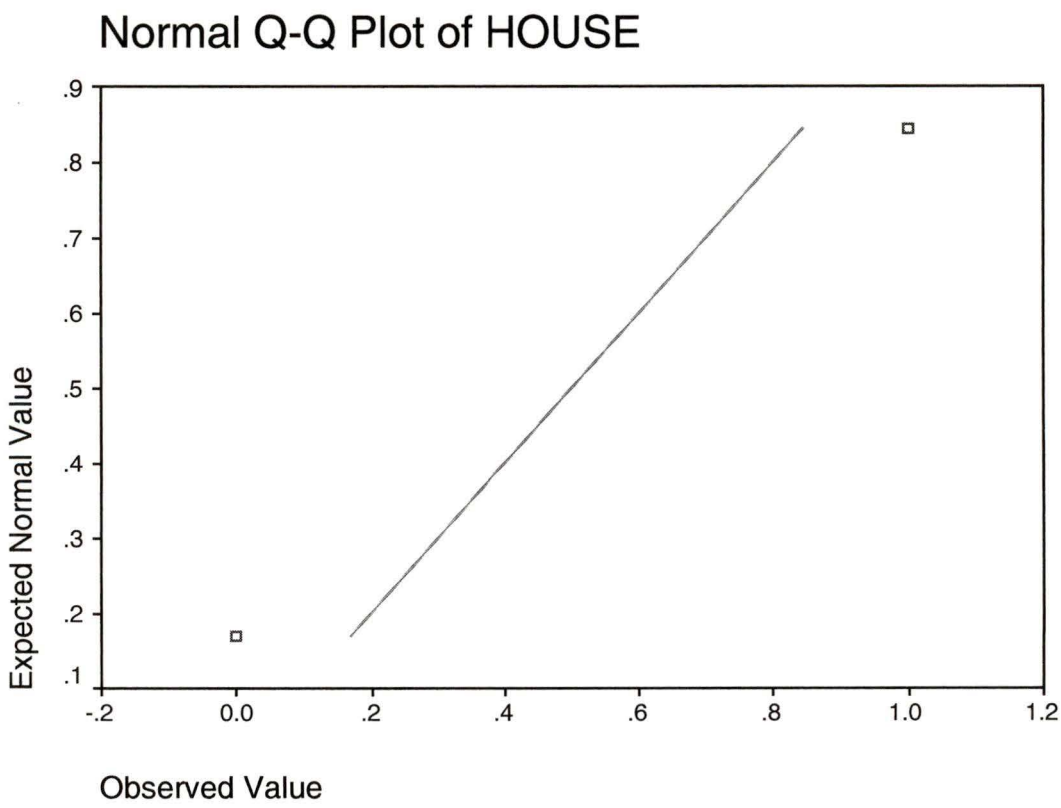

Normal Q-Q Plot of MMSE2
Expected Normal Value
Observed Value
0
100
200
300
400
500
600

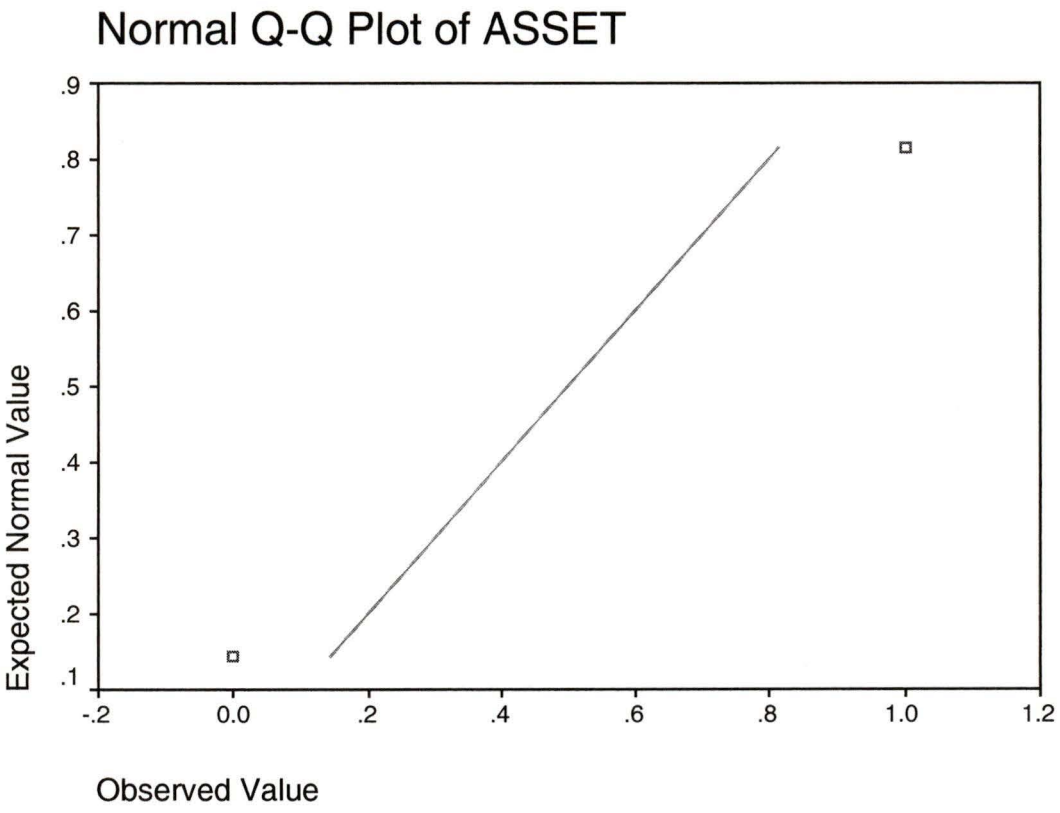

Normal Q-Q Plot of Extent of Care
Expected Normal Value
Observed Value
2
3
4
5
6
7
8
9
10
12

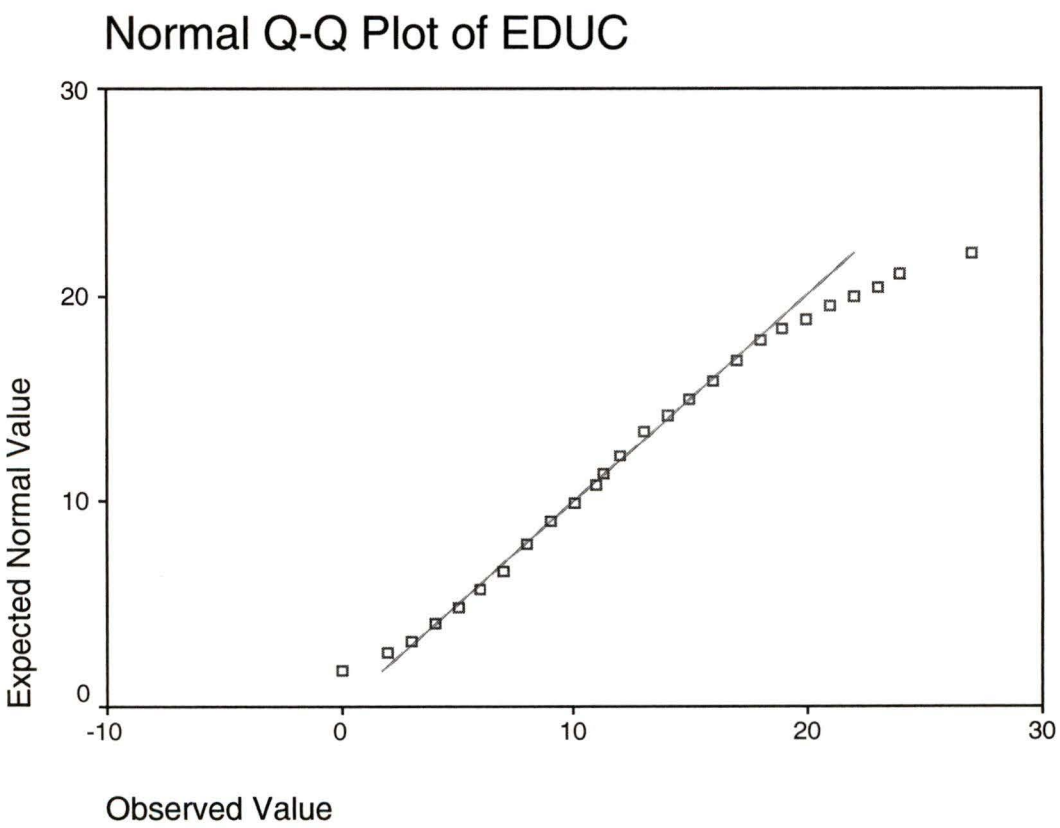

Normal Q-Q Plot of Respondent's gender
Expected Normal Value
1.0
.9
.8
.7
.6
.5
.4
.3
.2
-.2
0.0
.2
.4
.6
.8
1.0
1.2
Observed Value

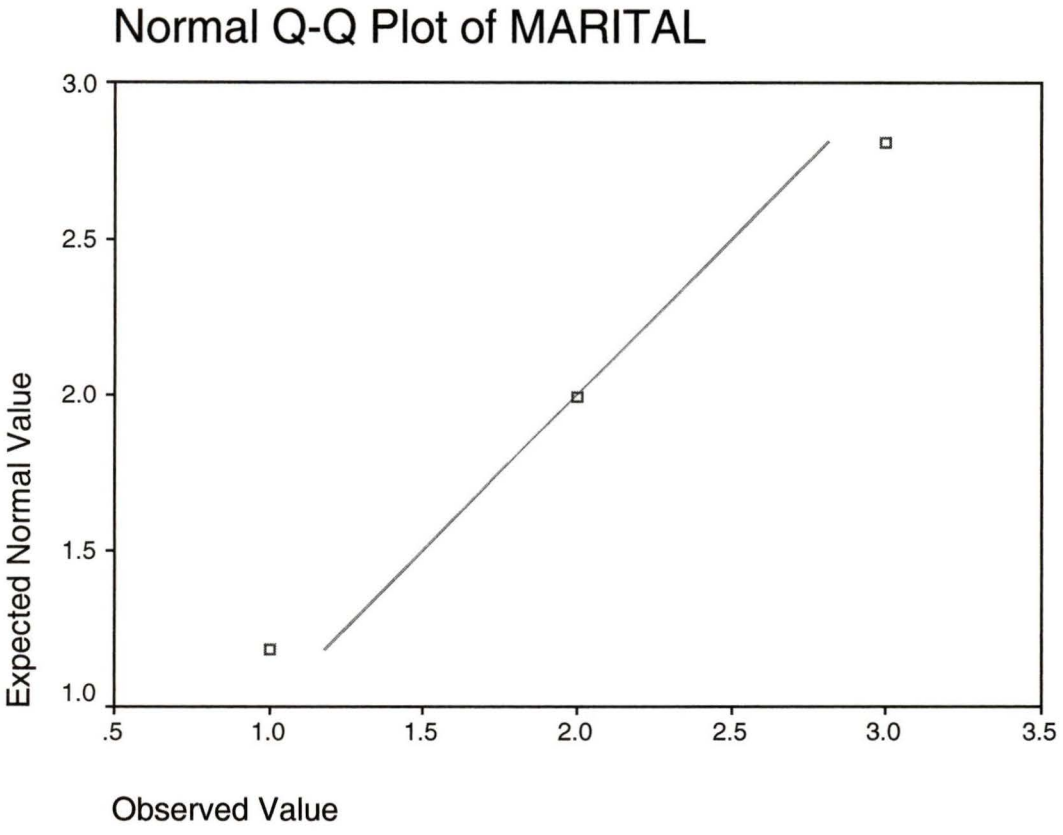

Normal Q-Q Plot of CLASS
Expected Normal Value
6
5
4
3
2
1
0
0
1
2
3
4
5
6
7
Observed Value

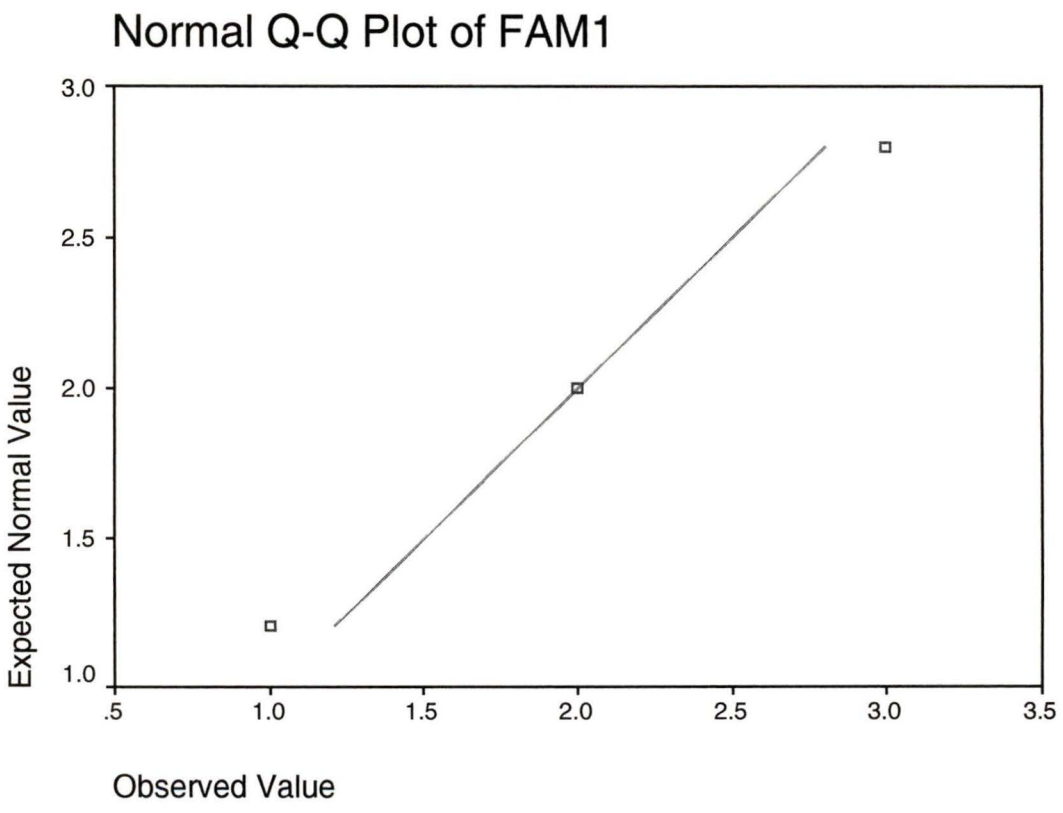

Normal Q-Q Plot of INCCAT
Expected Normal Value
4.5
4.0
3.5
3.0
2.5
2.0
1.5
1.0
0
1
2
3
4
5
6
Observed Value

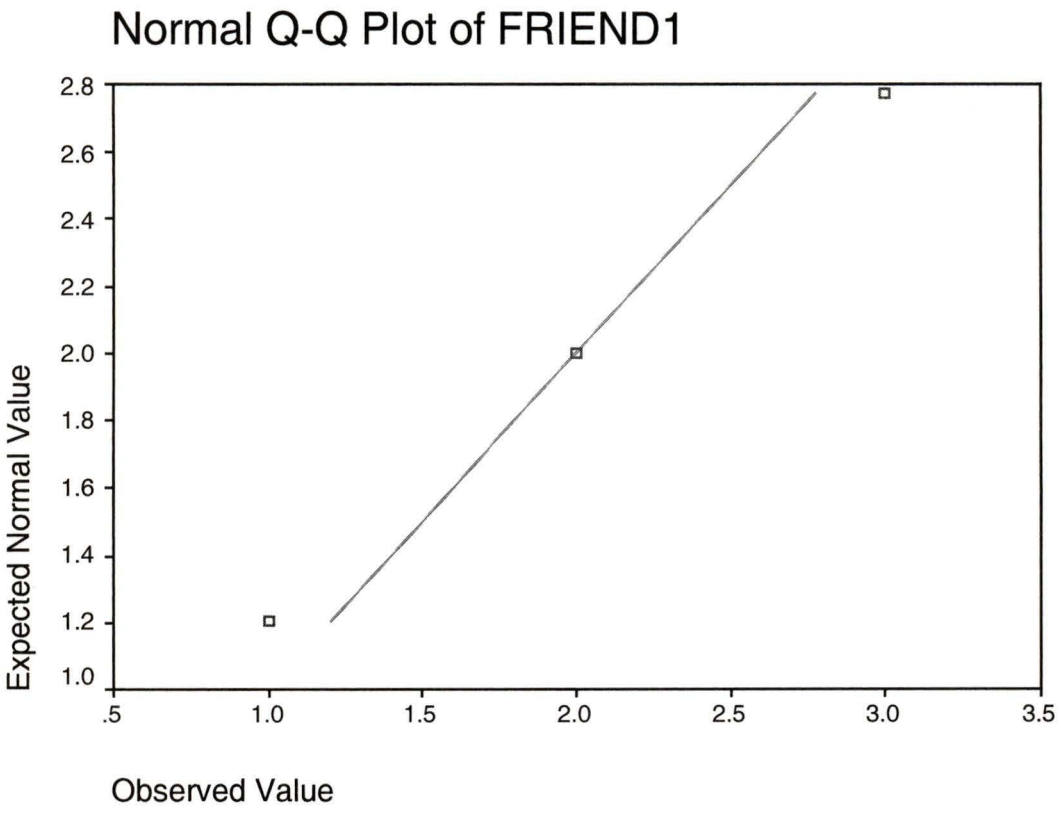

Normal Q-Q Plot of HOUSE
Expected Normal Value
.9
.8
.7
.6
.5
.4
.3
.2
.1
-.2
0.0
.2
.4
.6
.8
1.0
1.2
Observed Value

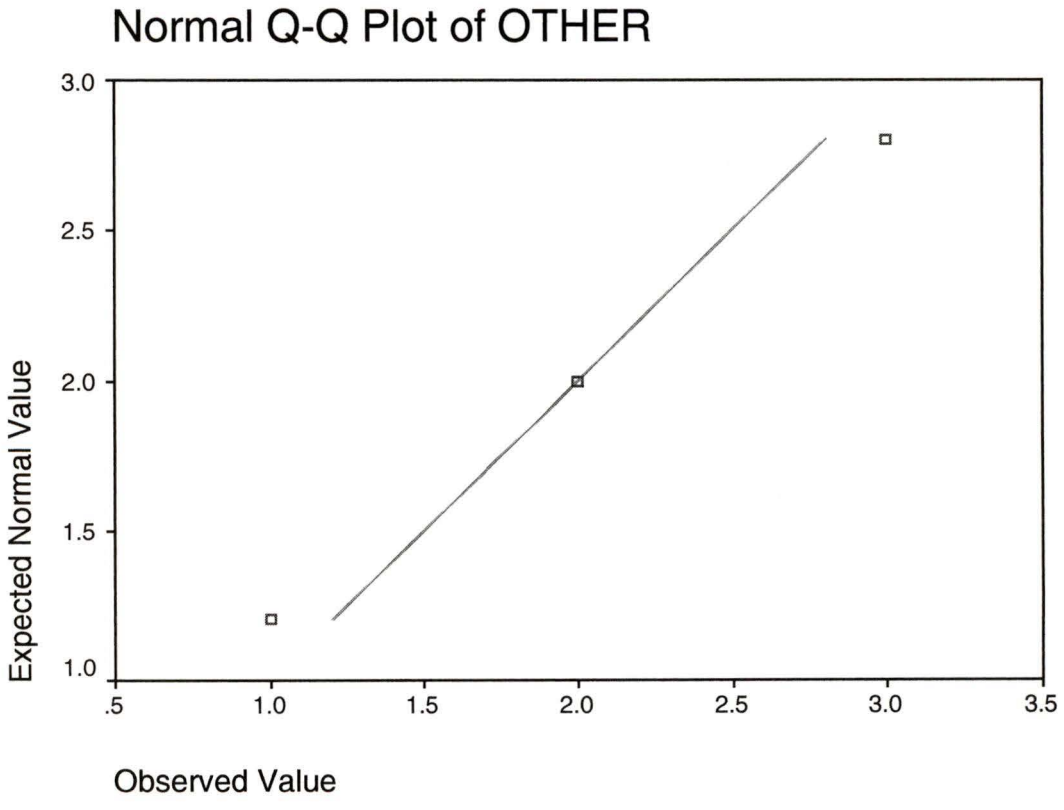

Normal Q-Q Plot of ASSET
Expected Normal Value
.9
.8
.7
.6
.5
.4
.3
.2
.1
-.2
0.0
.2
.4
.6
.8
1.0
1.2
Observed Value

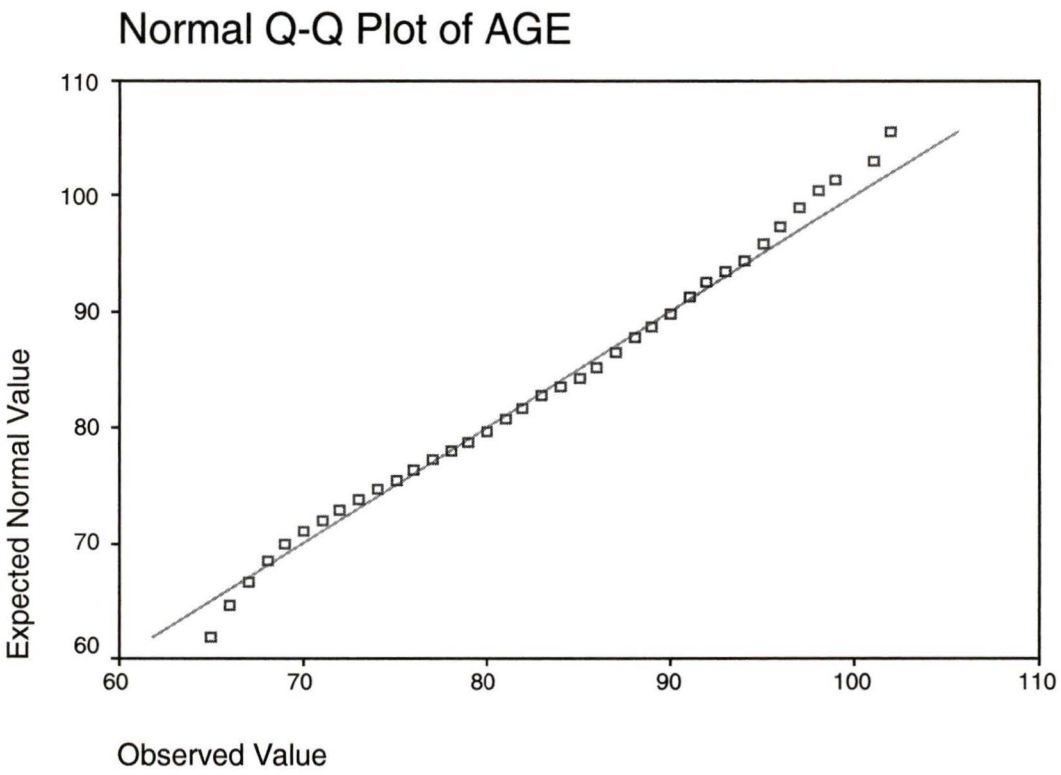

Normal Q-Q Plot of EDUC
Expected Normal Value
30
20
10
0
-10
0
10
20
30
Observed Value


Normal Q-Q Plot of MARITAL
Expected Normal Value
3.0
2.5
2.0
1.5
1.0
.5
1.0
1.5
2.0
2.5
3.0
3.5
Observed Value


Normal Q-Q Plot of FAM1
Expected Normal Value
3.0
2.5
2.0
1.5
1.0
.5
1.0
1.5
2.0
2.5
3.0
3.5
Observed Value

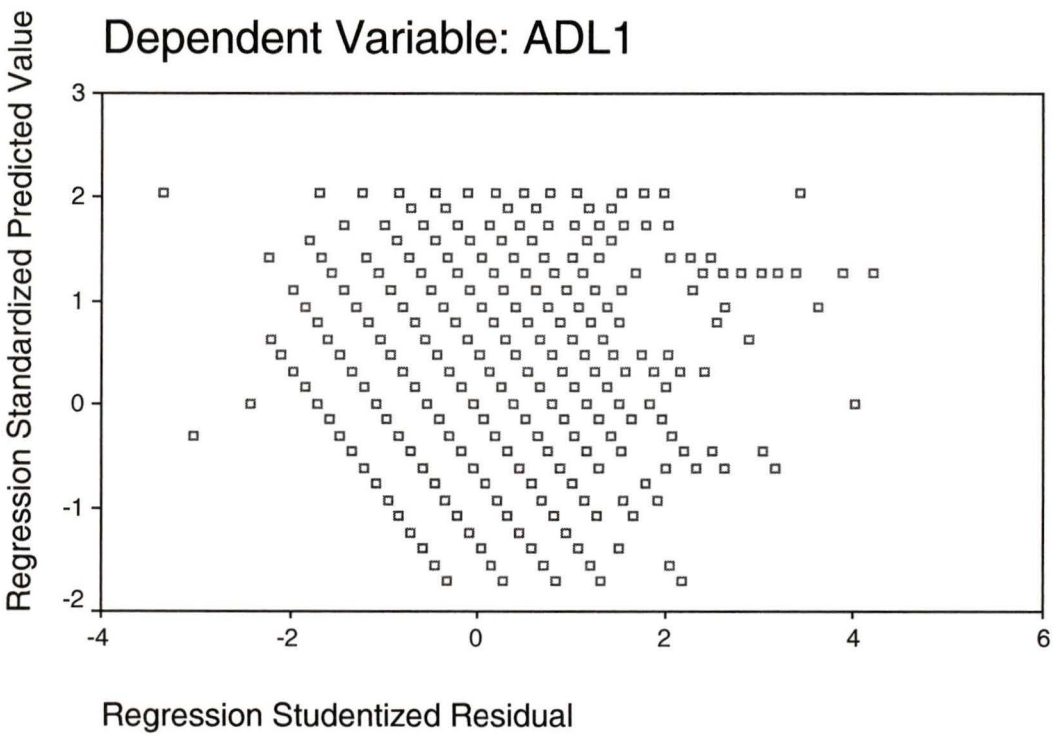

Normal Q-Q Plot of FRIEND1
Expected Normal Value
2.8
2.6
2.4
2.2
2.0
1.8
1.6
1.4
1.2
1.0
.5
1.0
1.5
2.0
2.5
3.0
3.5
Observed Value


Normal Q-Q Plot of OTHER
Expected Normal Value
3.0
2.5
2.0
1.5
1.0
.5
1.0
1.5
2.0
2.5
3.0
3.5
Observed Value

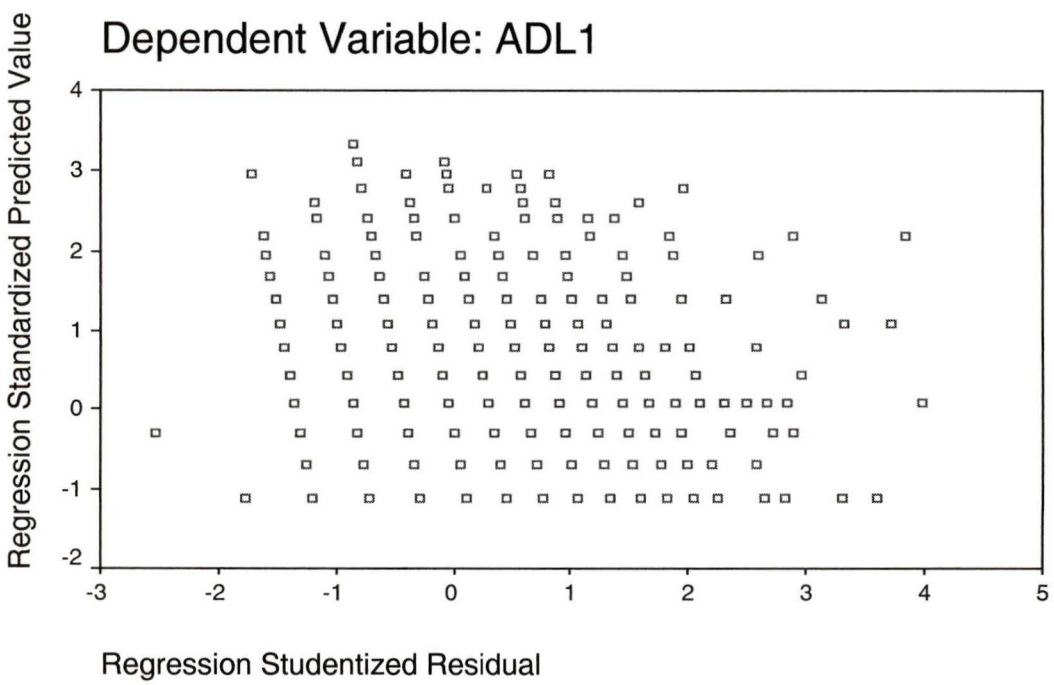

Normal Q-Q Plot of AGE
Expected Normal Value
Observed Value
110
100
90
80
70
60
60
70
80
90
100
110

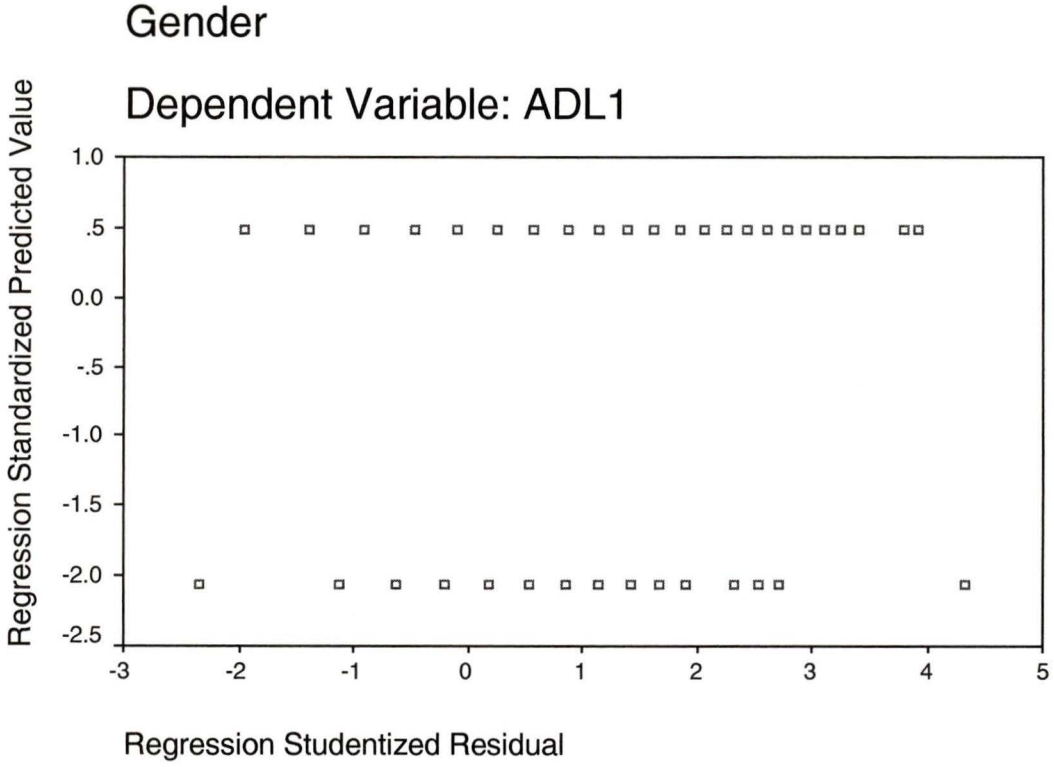
APPENDIX C

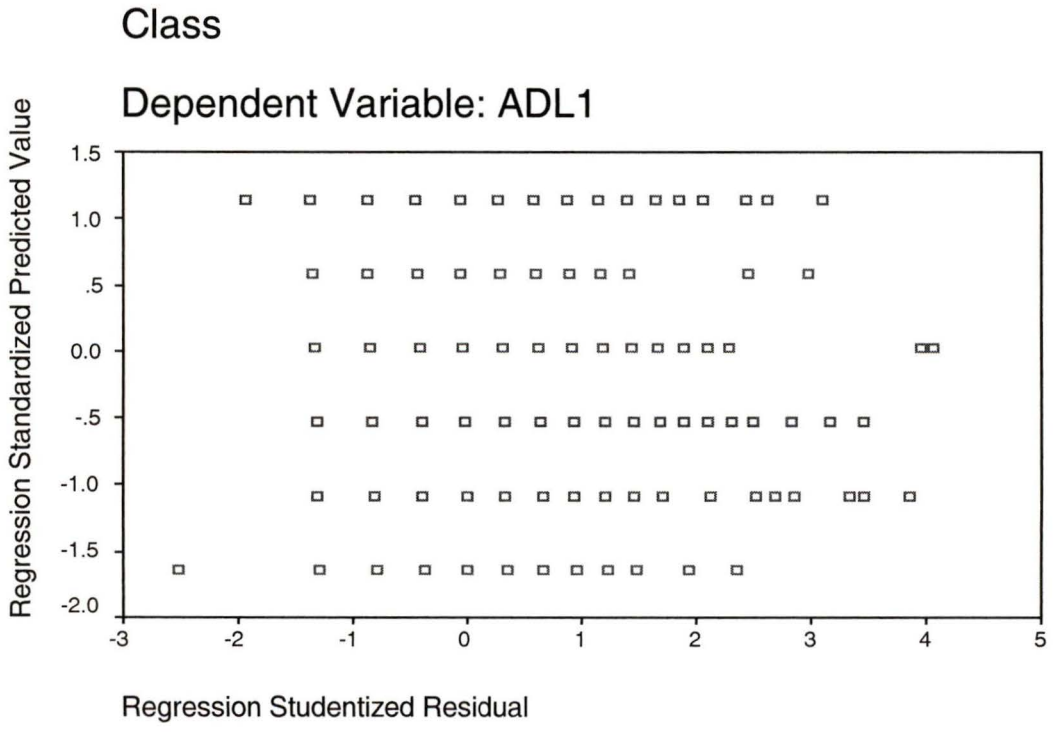
IADL


Dependent Variable: ADL1
Regression Standardized Predicted Value
3
2
1
0
-1
-2
-4
-2
0
2
4
6
Regression Studentized Residual

MMSE

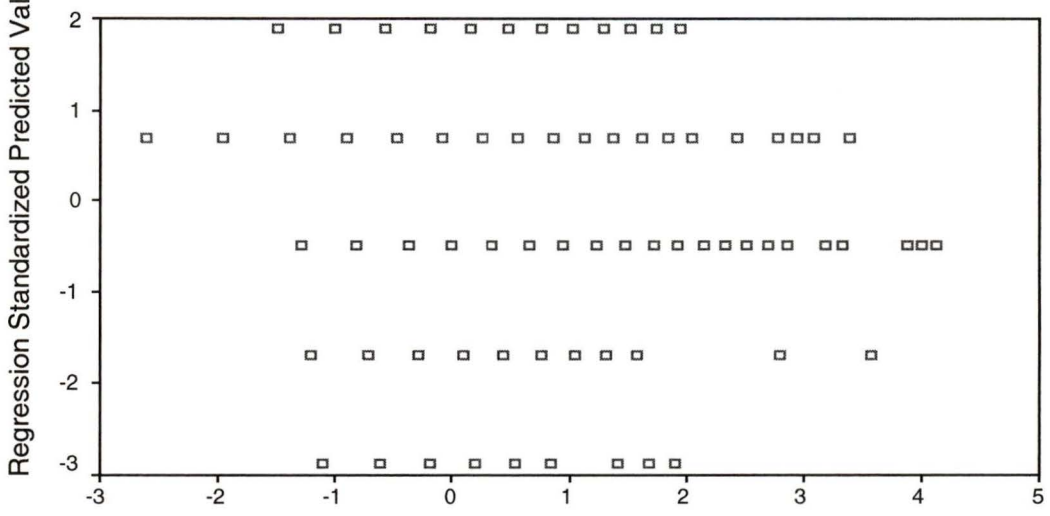

Dependent Variable: ADL1
Regression Standardized Predicted Value
4
3
2
1
0
-1
-2
-3
-2
-1
0
1
2
3
4
5
Regression Studentized Residual


Gender
Dependent Variable: ADL1
Regression Standardized Predicted Value
1.0
.5
0.0
-.5
-1.0
-1.5
-2.0
-2.5
-3
-2
-1
0
1
2
3
4
5
Regression Studentized Residual


Class
Dependent Variable: ADL1
Regression Standardized Predicted Value
1.5
1.0
.5
0.0
-.5
-1.0
-1.5
-2.0
-3
-2
-1
0
1
2
3
4
5
Regression Studentized Residual

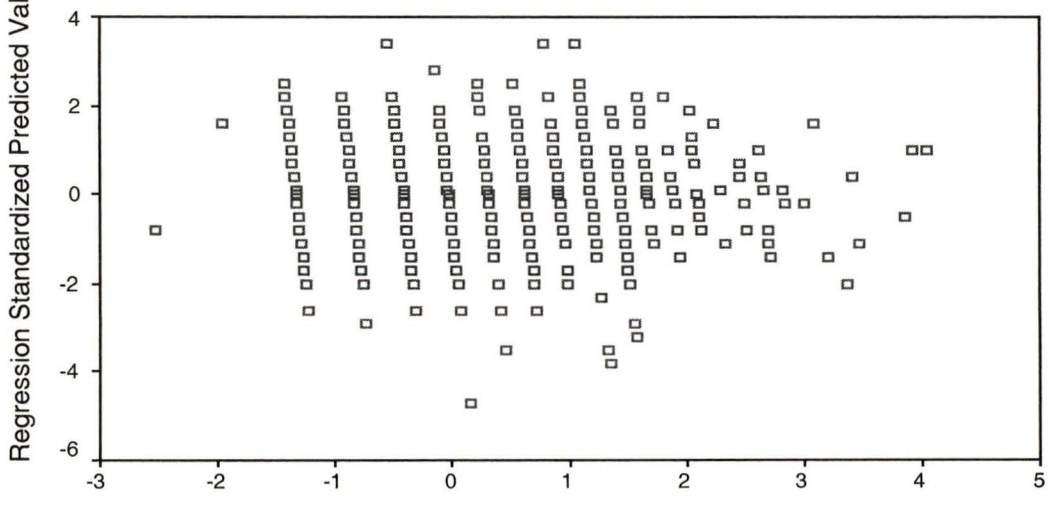
Income - Categorical

Dependent Variable: ADL1



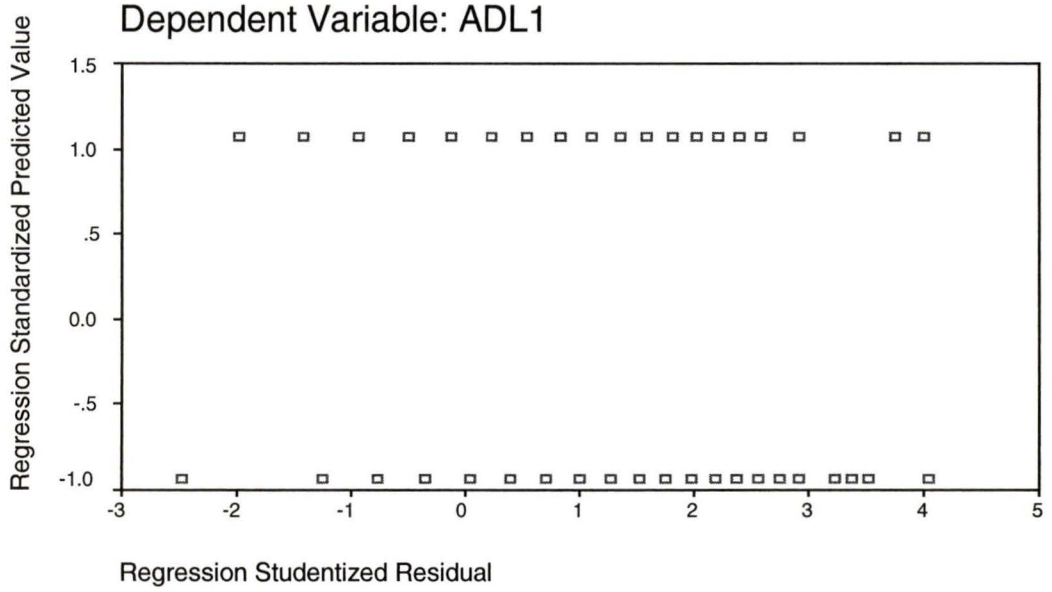
Education

Dependent Variable: ADL1



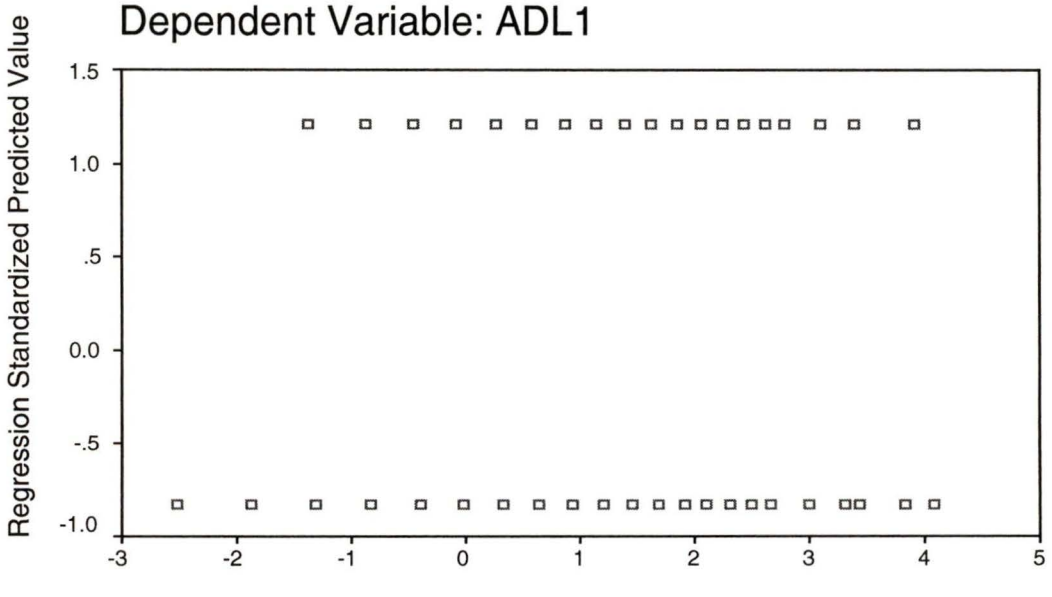
Home Ownership

Dependent Variable: ADL1



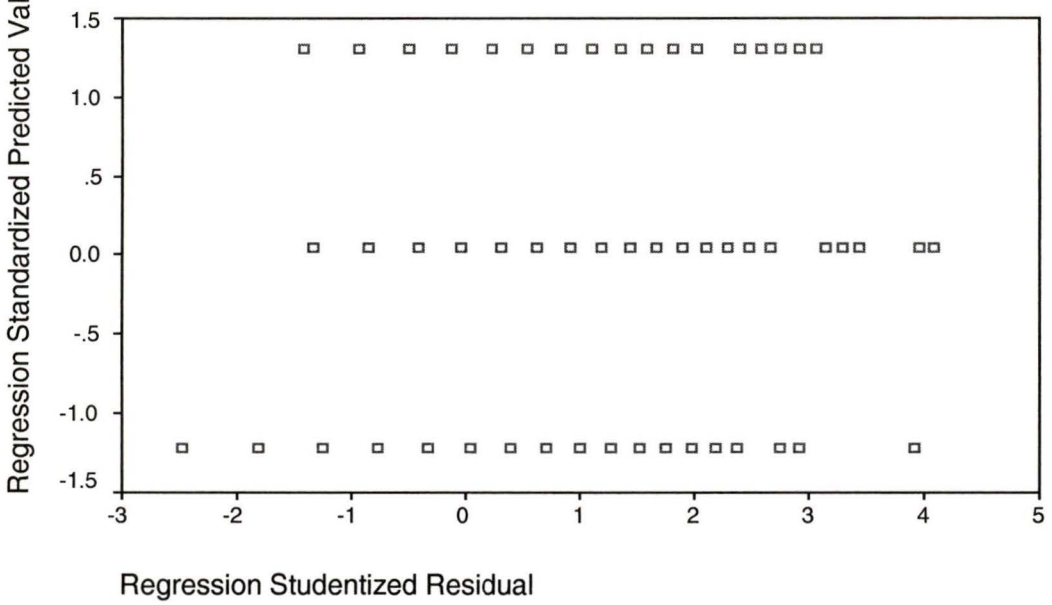
Presence of Assets

Dependent Variable: ADL1



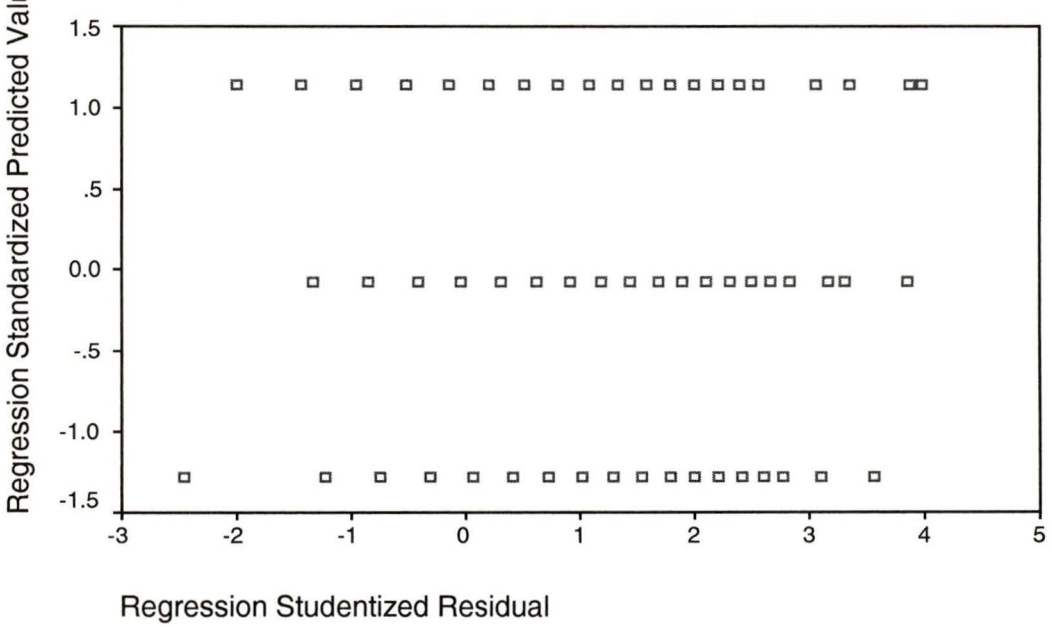
Family Members

Dependent Variable: ADL1

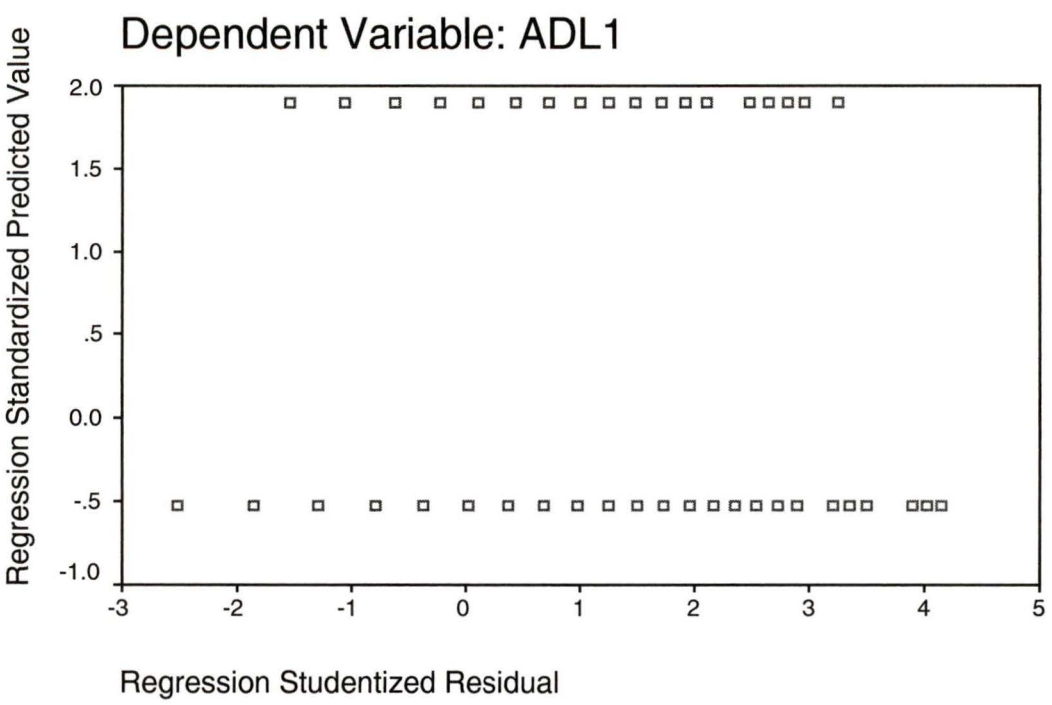


Friends

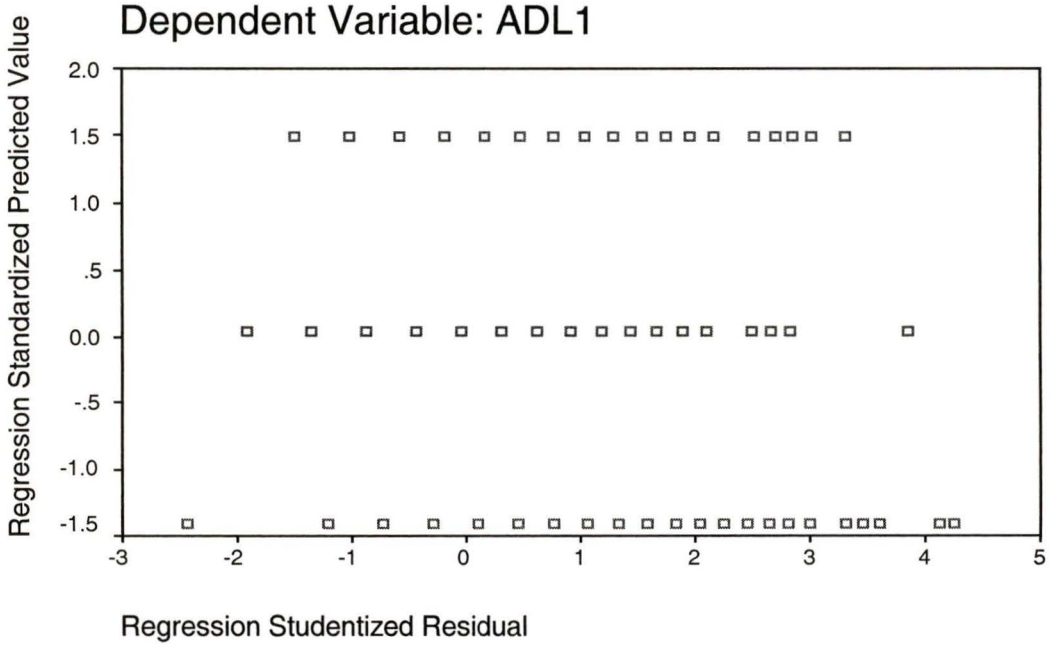
Dependent Variable: ADL1



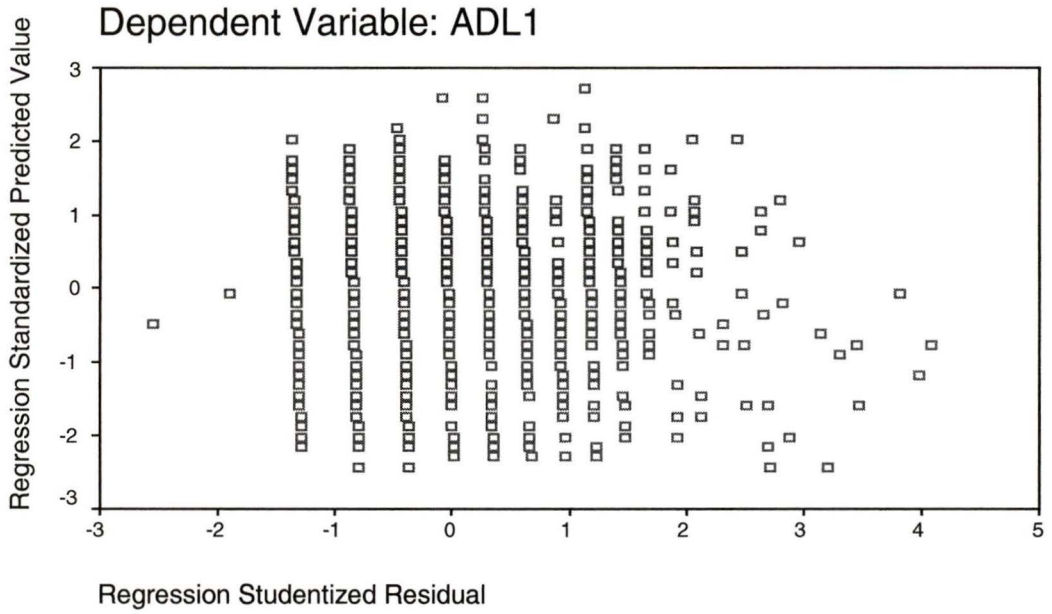
Others



Marital Status/Living Arrangements



Age


Dependent Variable: ADL1
Regression Standardized Predicted Value
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2
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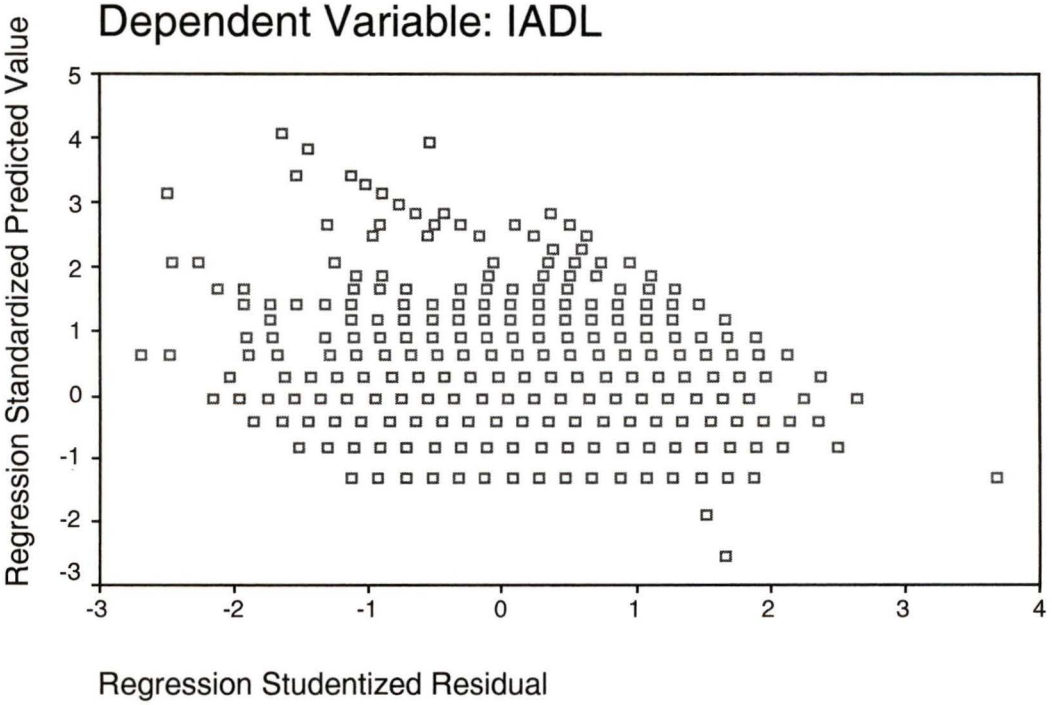
0
-1
-2
-3
-3
-2
-1
0
1
2
3
4
5
Regression Studentized Residual

ADL


Dependent Variable: IADL
Regression Standardized Predicted Value
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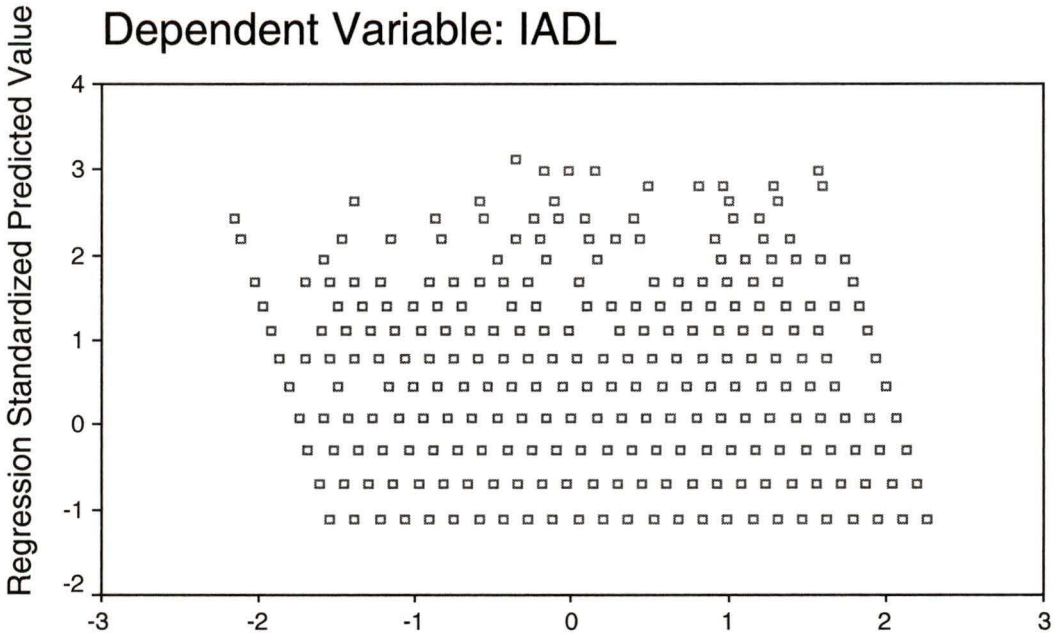
4
3
2
1
0
-1
-2
-3
-3
-2
-1
0
1
2
3
4
Regression Studentized Residual

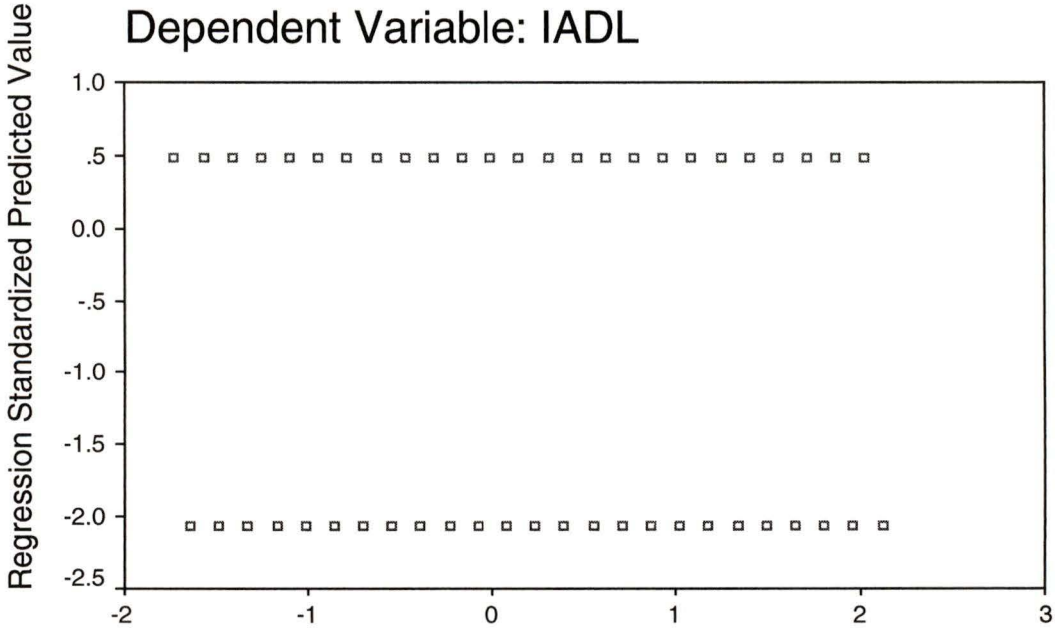
MMSE

Dependent Variable: IADL

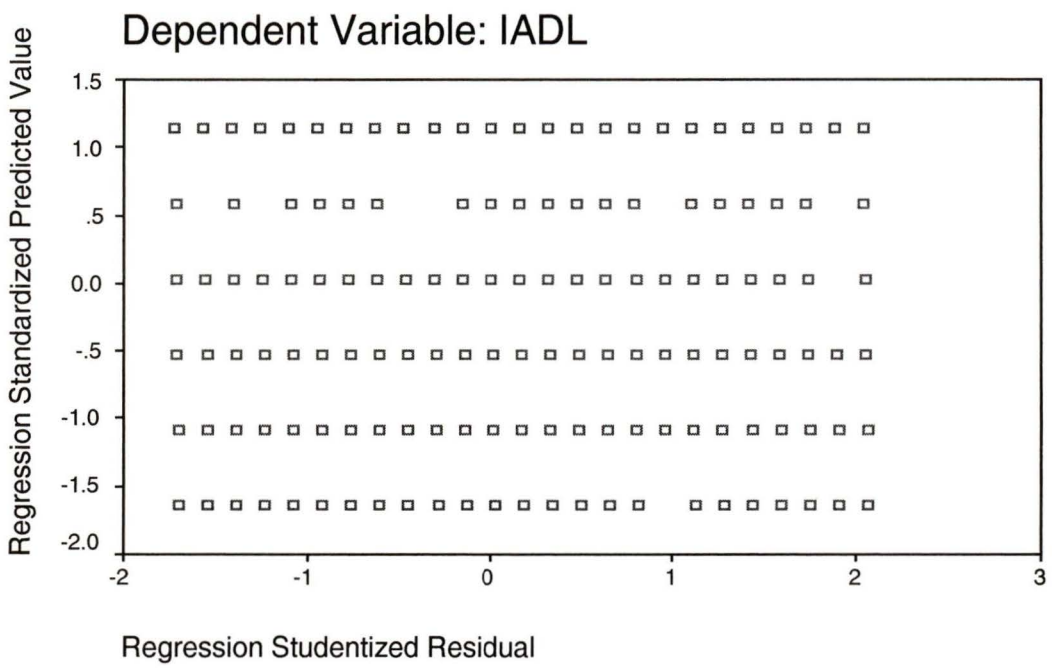


Gender

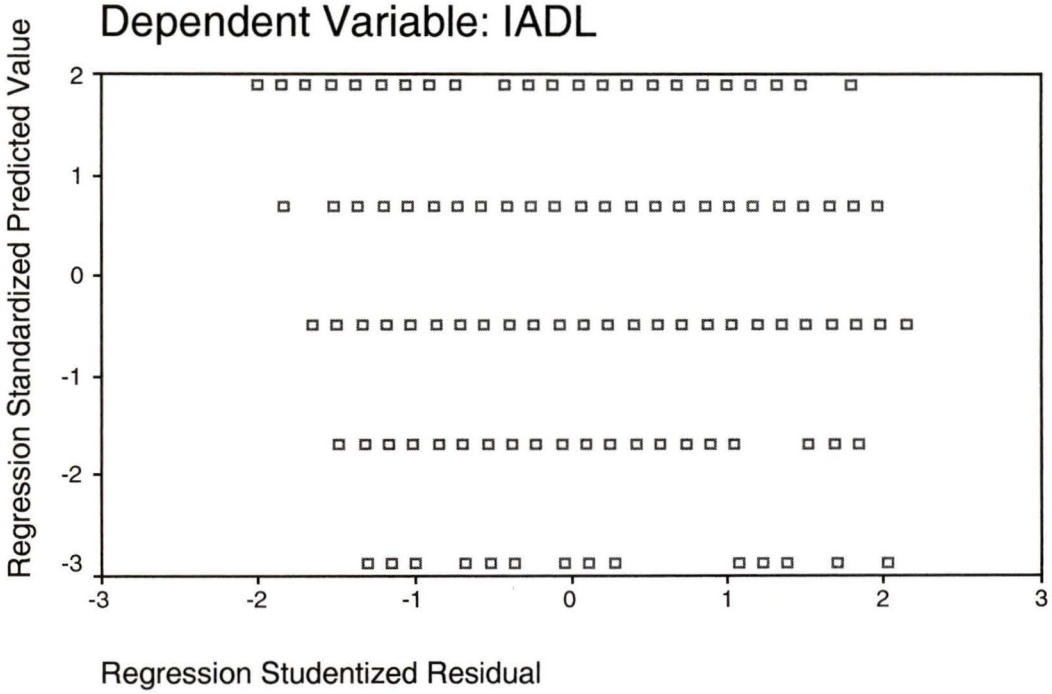
Dependent Variable: IADL



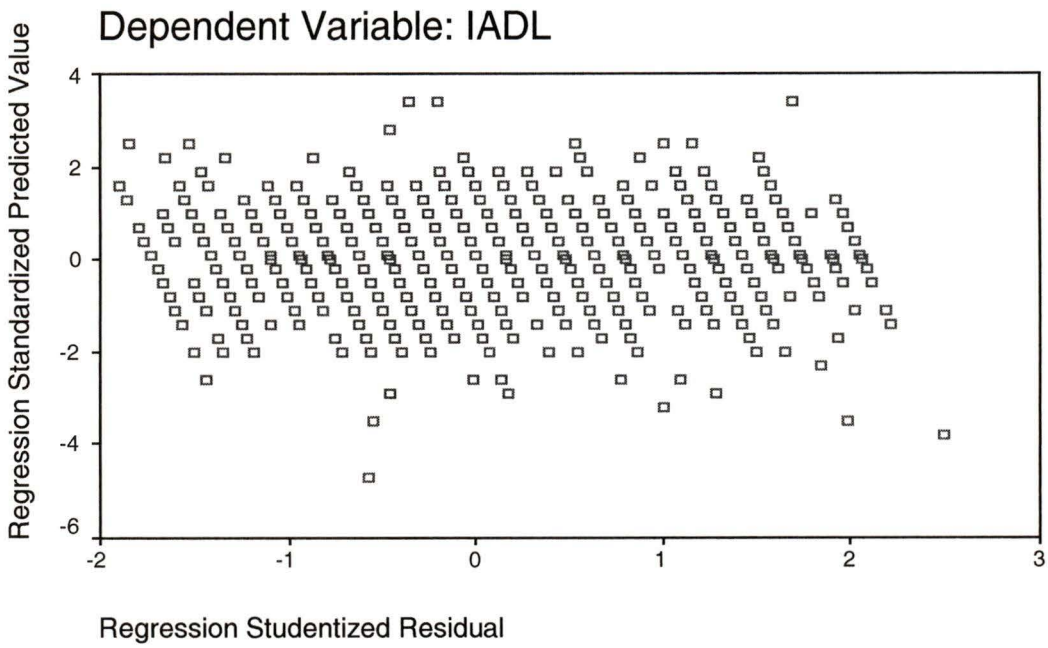
Class



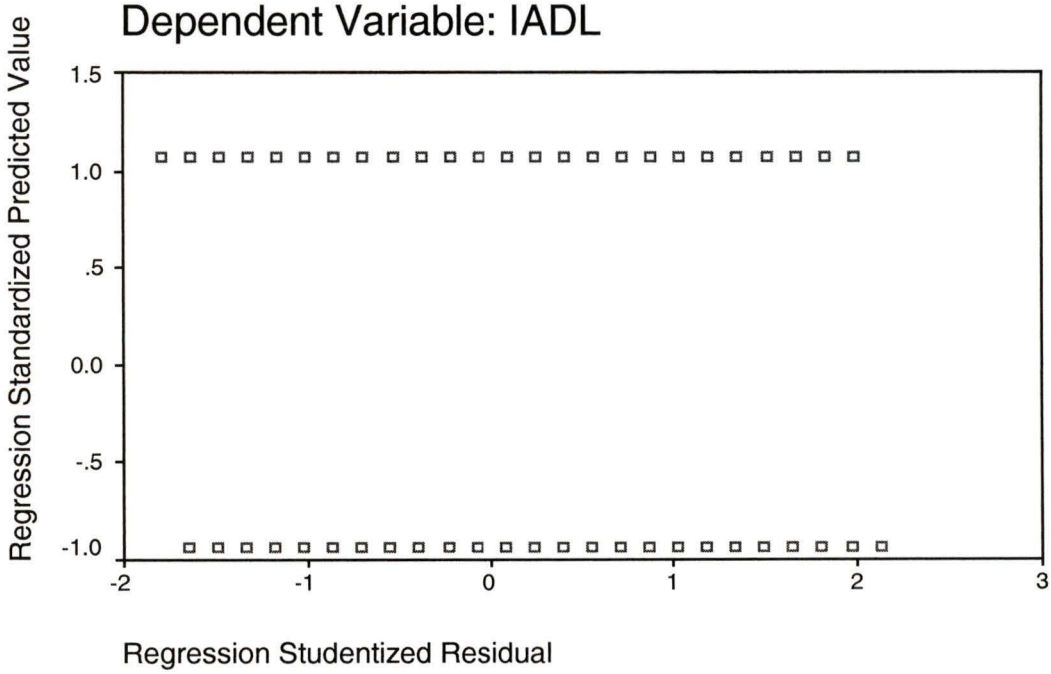
Income Categorical

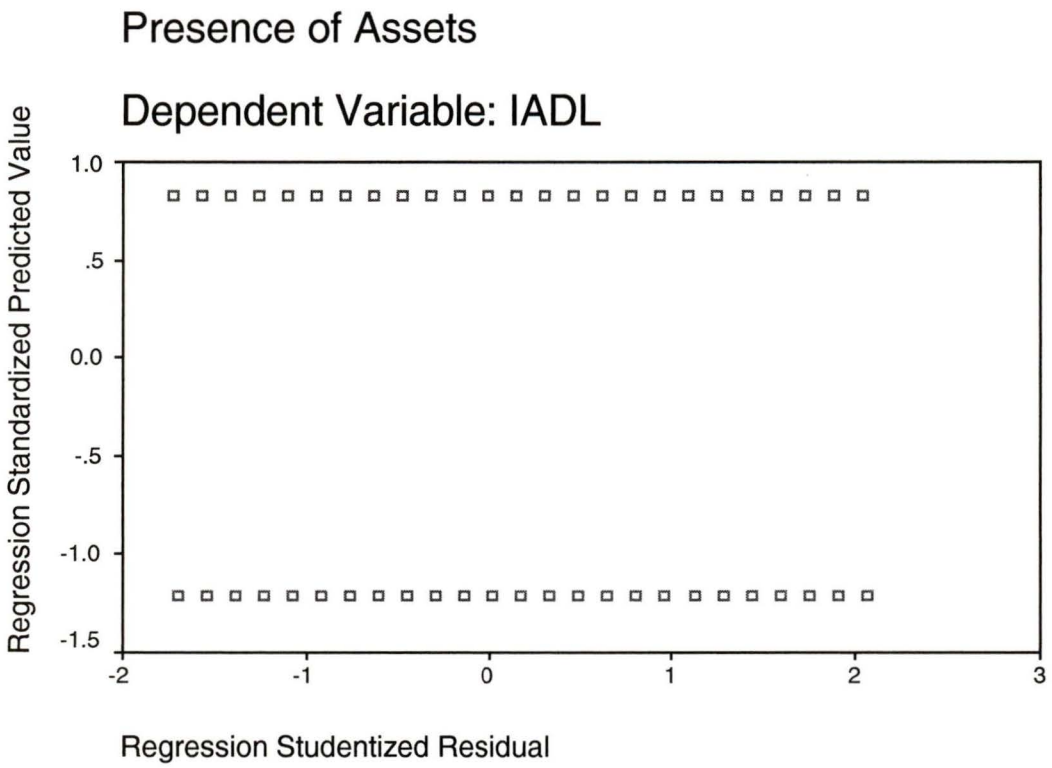


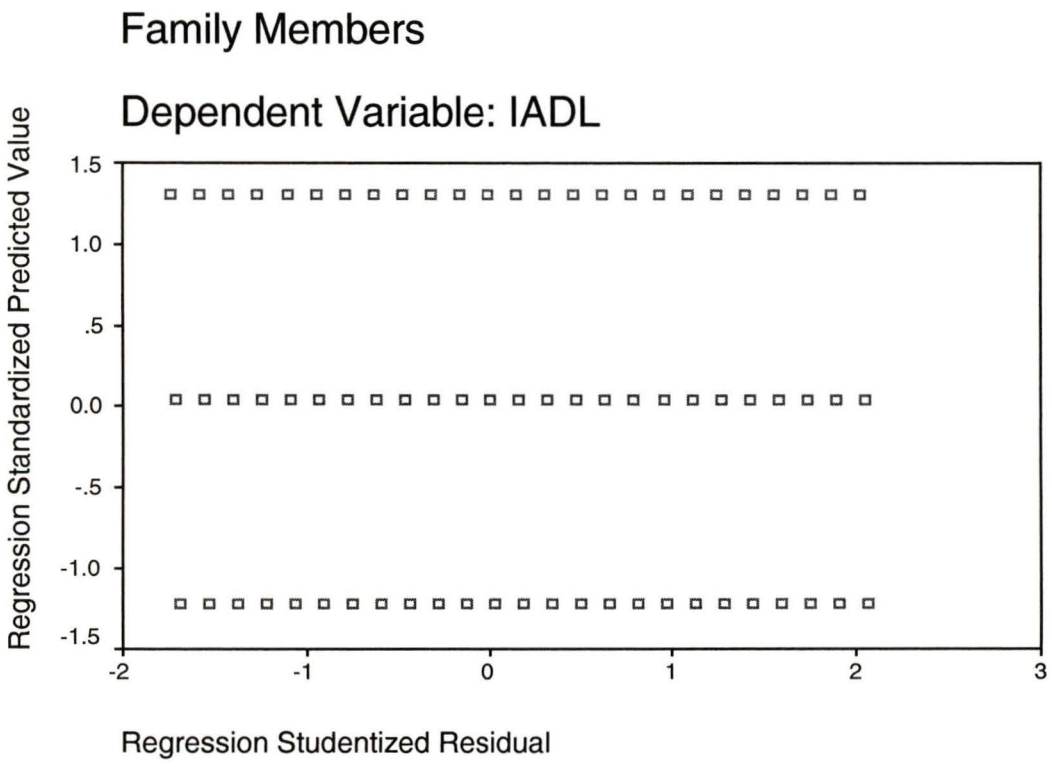
Education



Home Ownership

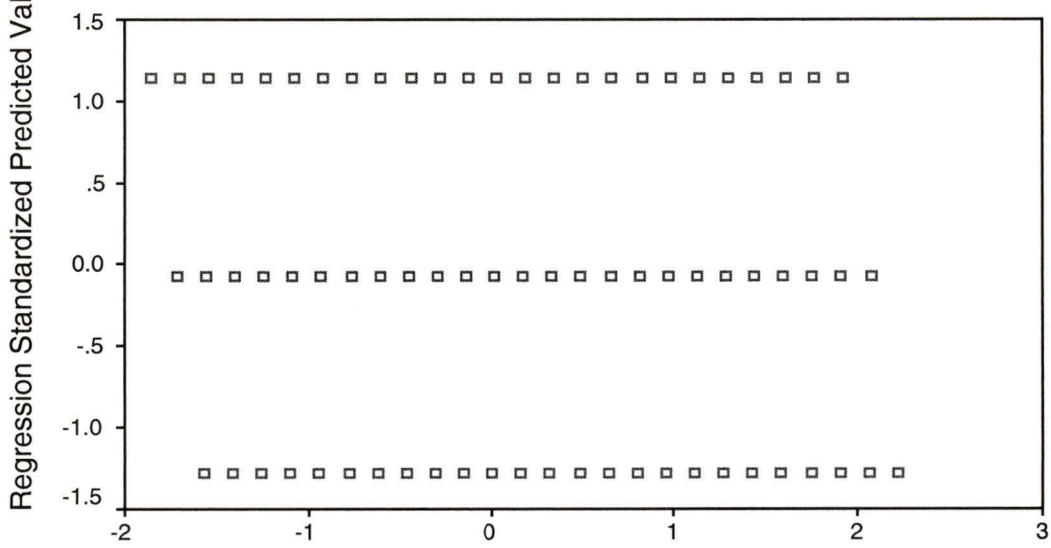



Presence of Assets
Dependent Variable: IADL
Regression Standardized Predicted Value
1.0
.5
0.0
-.5
-1.0
-1.5
-2
-1
0
1
2
3
Regression Studentized Residual


Family Members
Dependent Variable: IADL
Regression Standardized Predicted Value
1.5
1.0
.5
0.0
-.5
-1.0
-1.5
-2
-1
0
1
2
3
Regression Studentized Residual

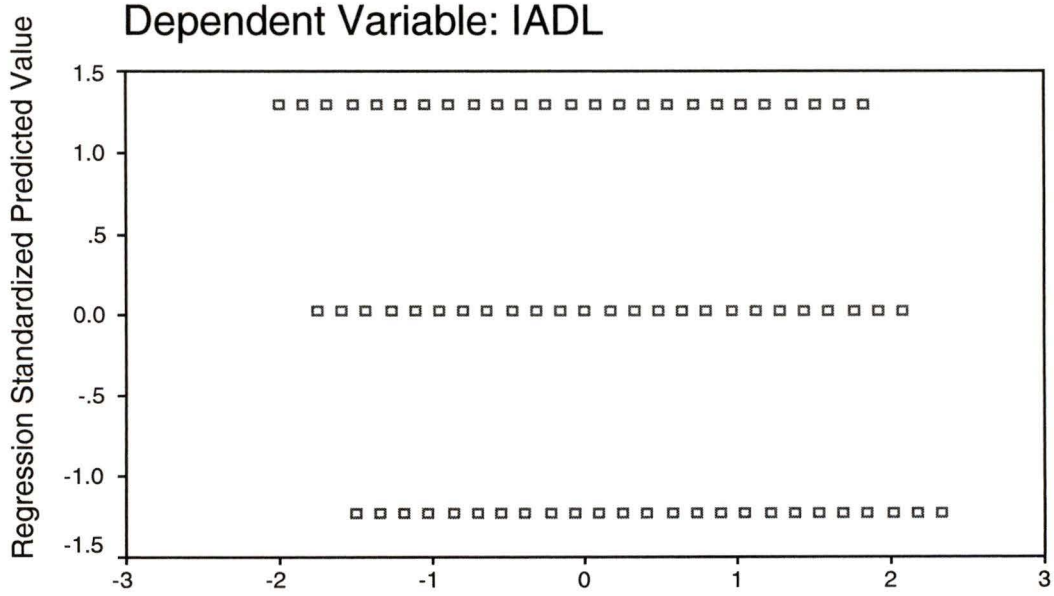
Friends

Dependent Variable: IADL



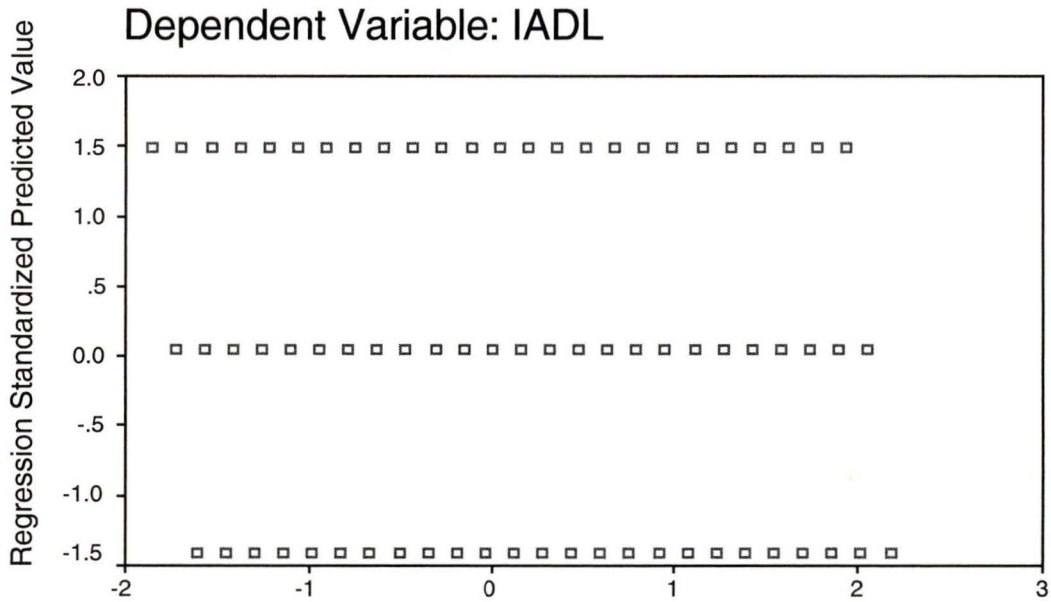
Others

Dependent Variable: IADL



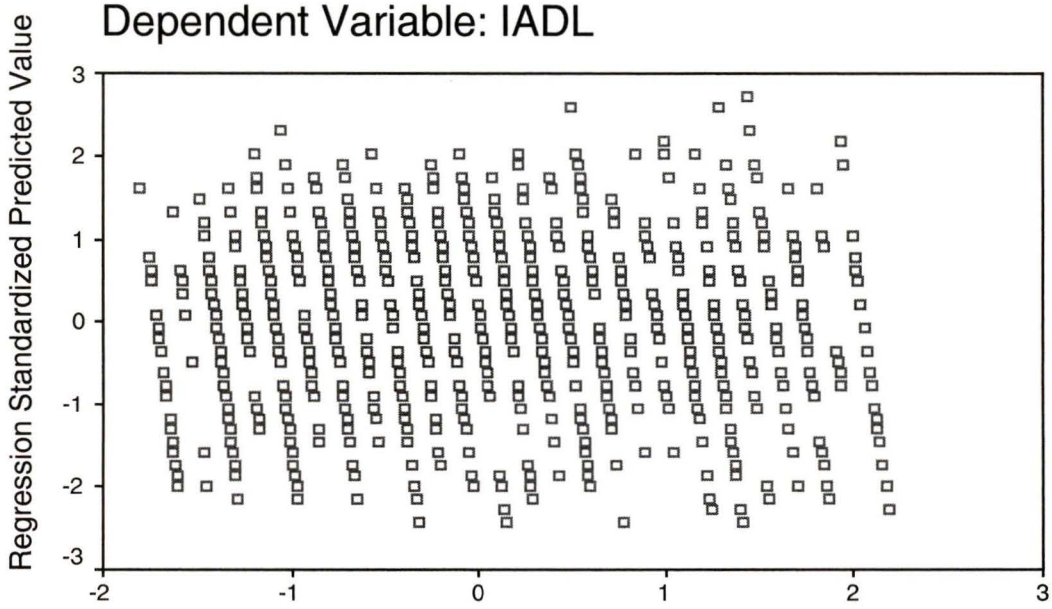
Marital Status/Living Arrangements

Dependent Variable: IADL

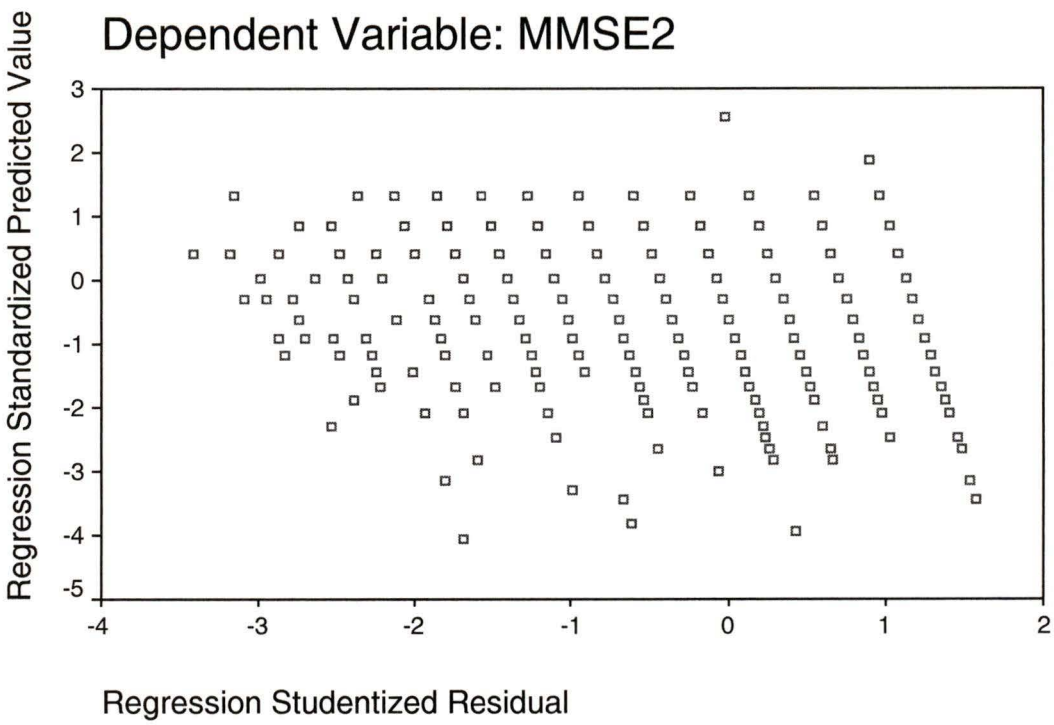


Age

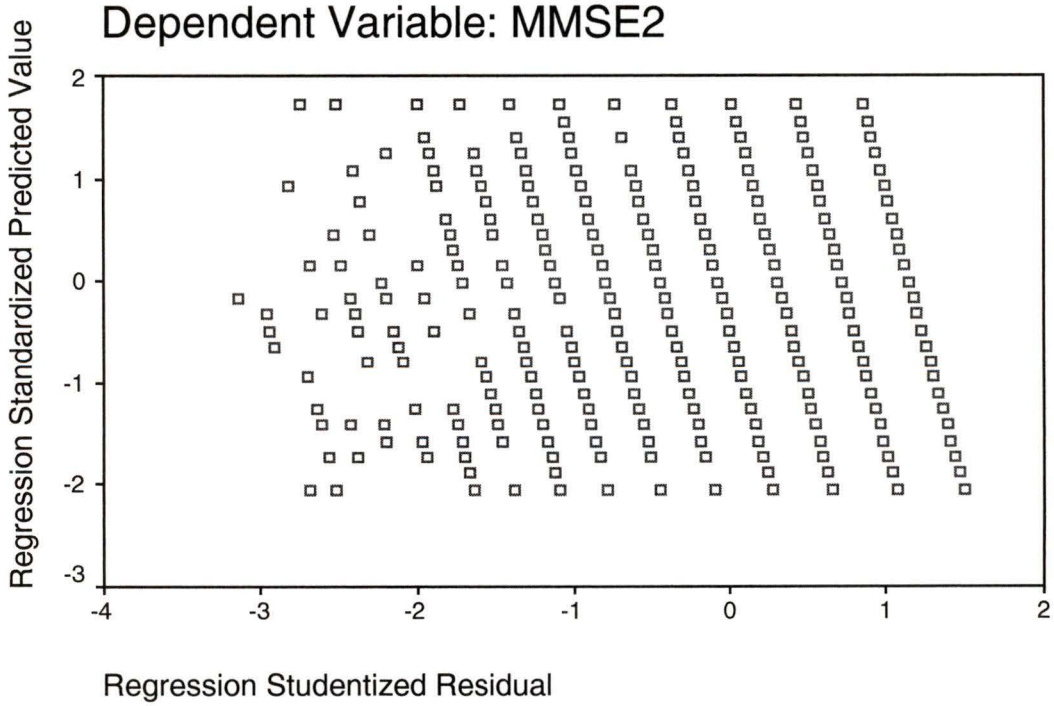
Dependent Variable: IADL



ADL

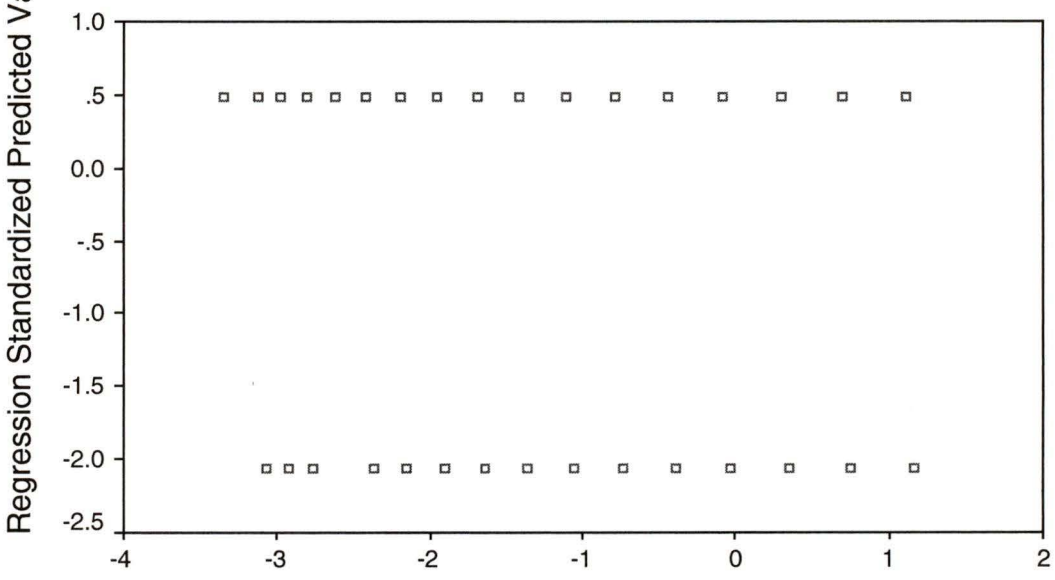

Dependent Variable: MMSE2
Regression Standardized Predicted Value
3
2
1
0
-1
-2
-3
-4
-5
-4
-3
-2
-1
0
1
2
Regression Studentized Residual

IADL


Dependent Variable: MMSE2
Regression Standardized Predicted Value
2
1
0
-1
-2
-3
-4
-3
-2
-1
0
1
2
Regression Studentized Residual

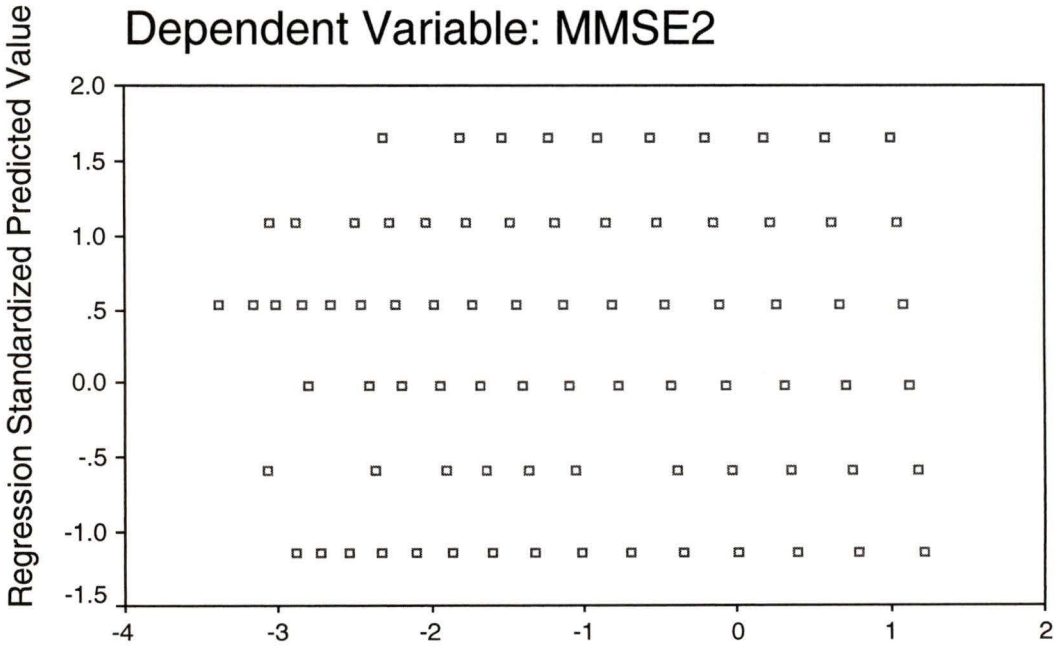
Gender

Dependent Variable: MMSE2



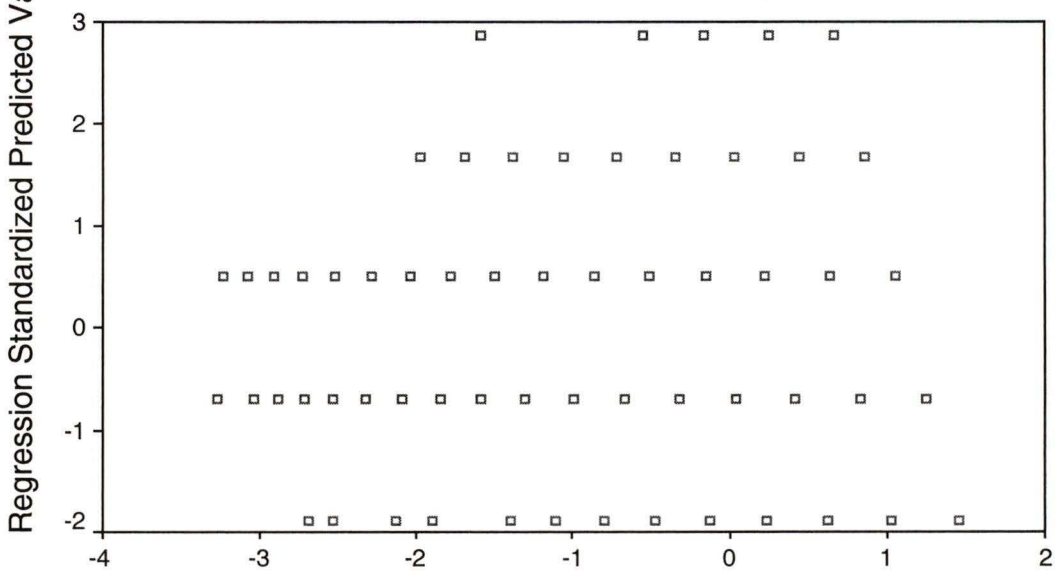
Class

Dependent Variable: MMSE2



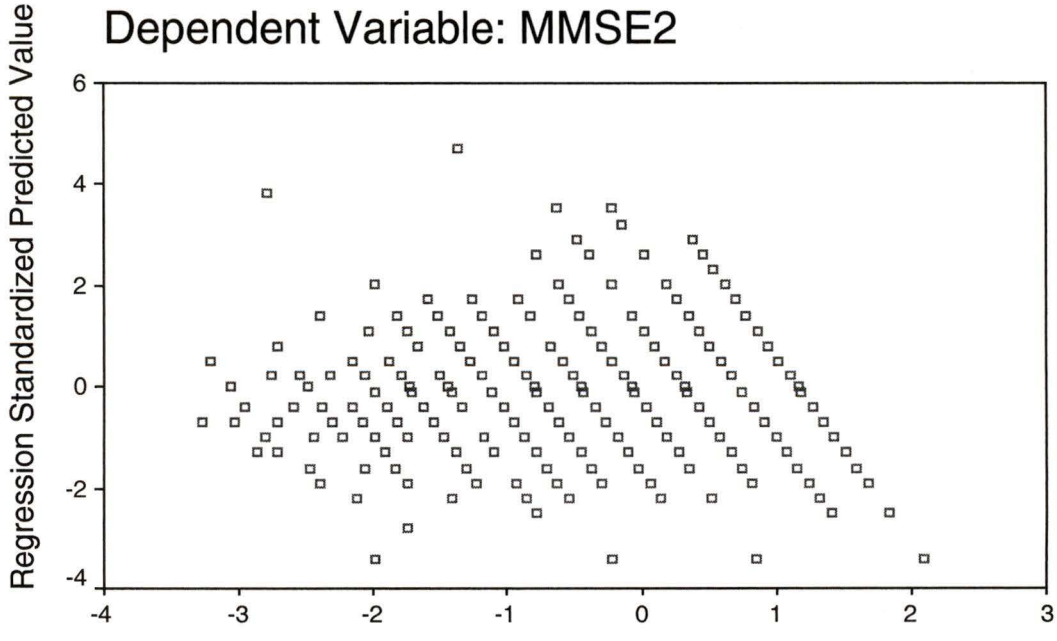
Income

Dependent Variable: MMSE2

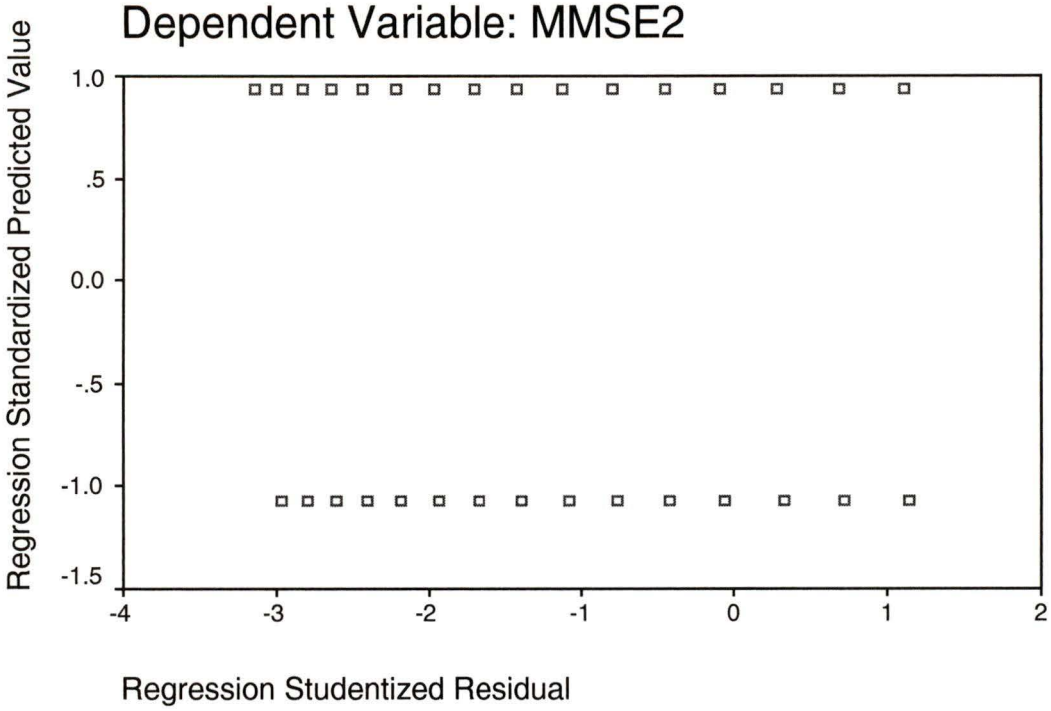


Education

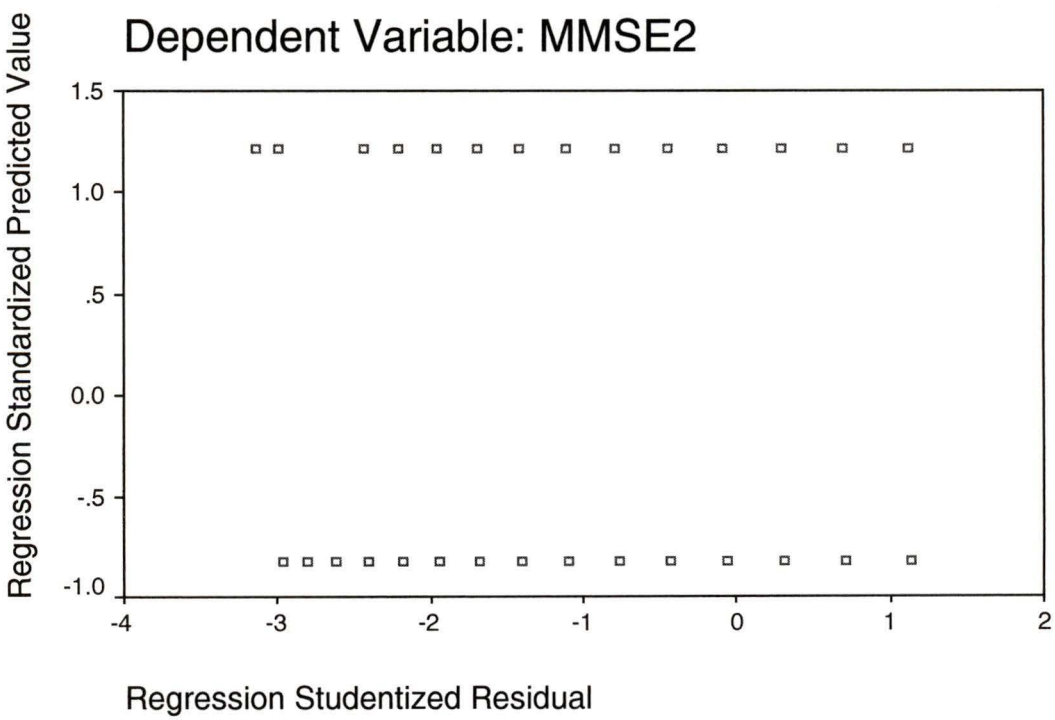
Dependent Variable: MMSE2



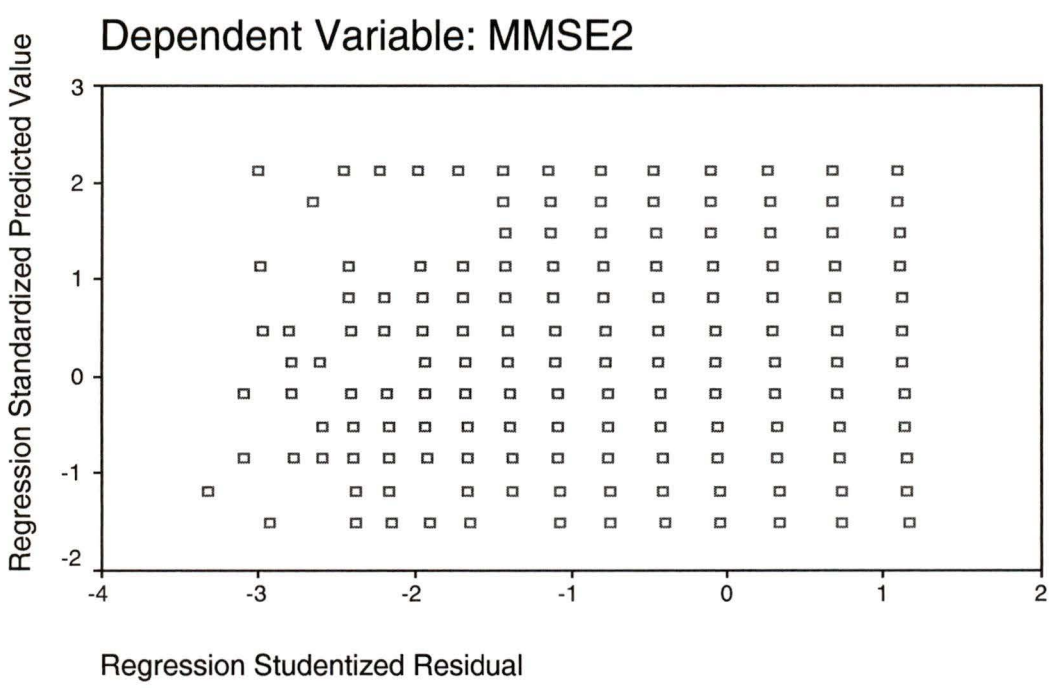
Home Ownership



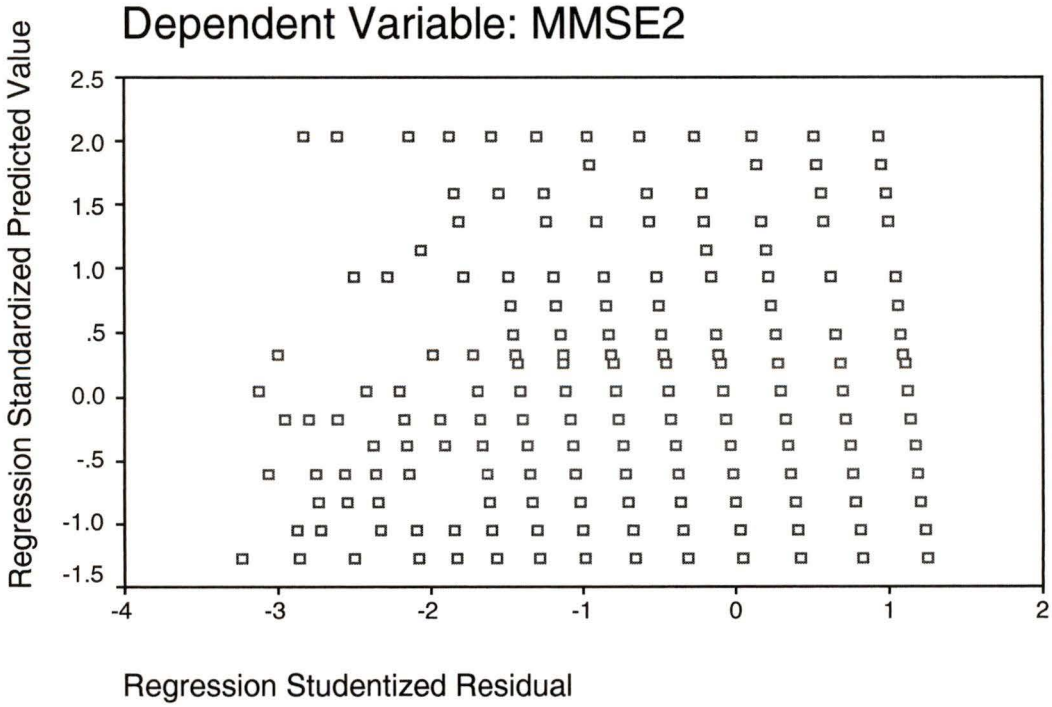
Assets



Family

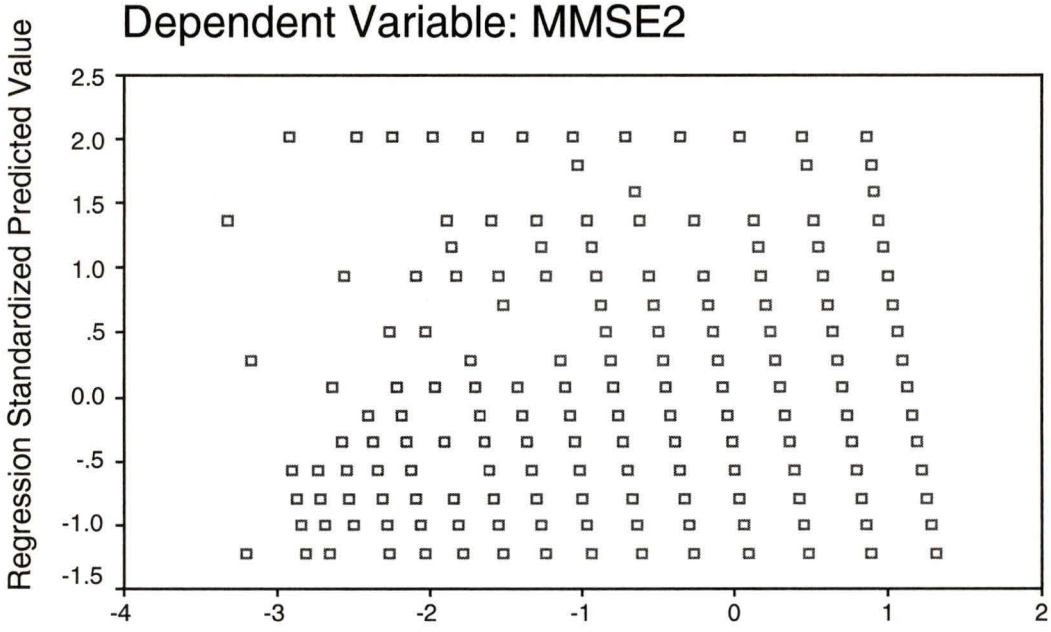


Friends



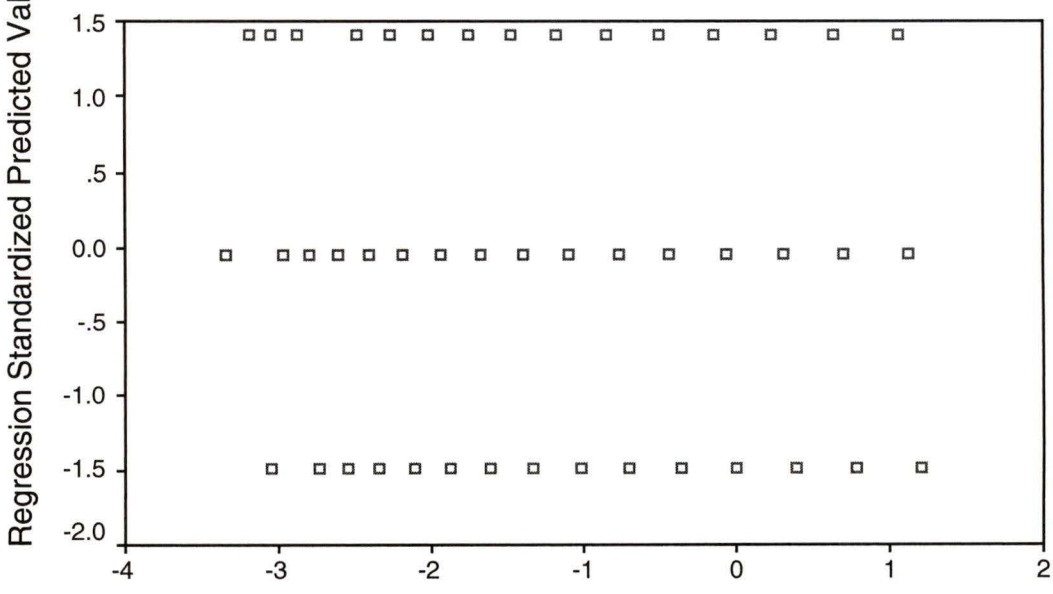
Others

Dependent Variable: MMSE2



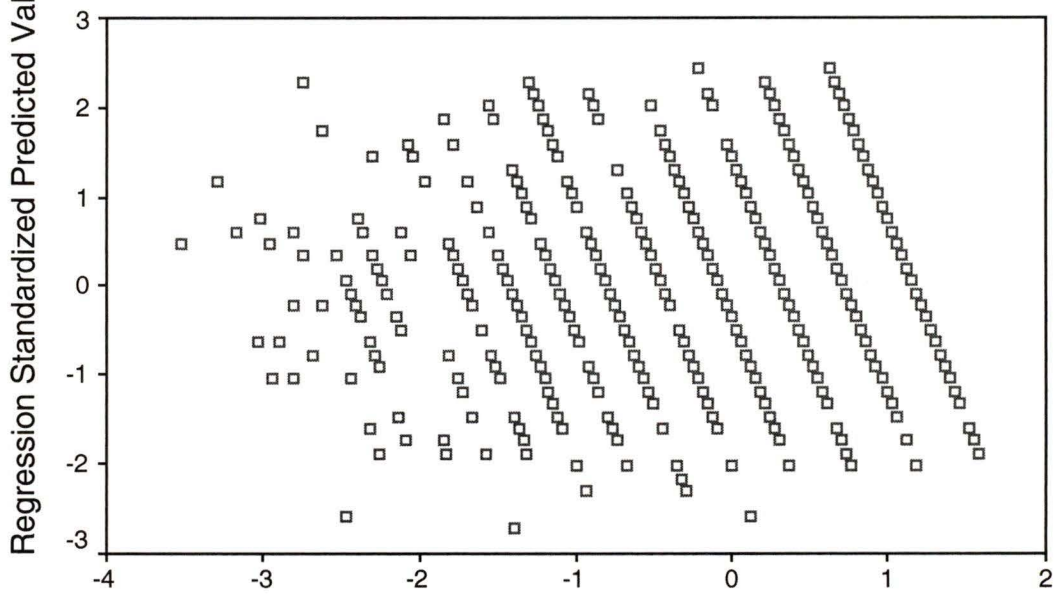
Marital Status/Living Arrangements

Dependent Variable: MMSE2



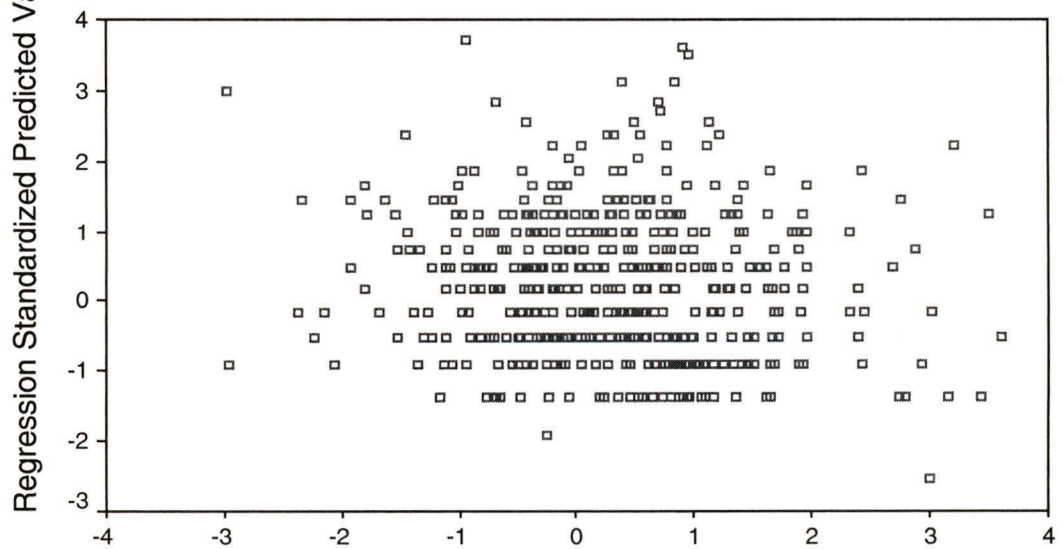
Age

Dependent Variable: MMSE2

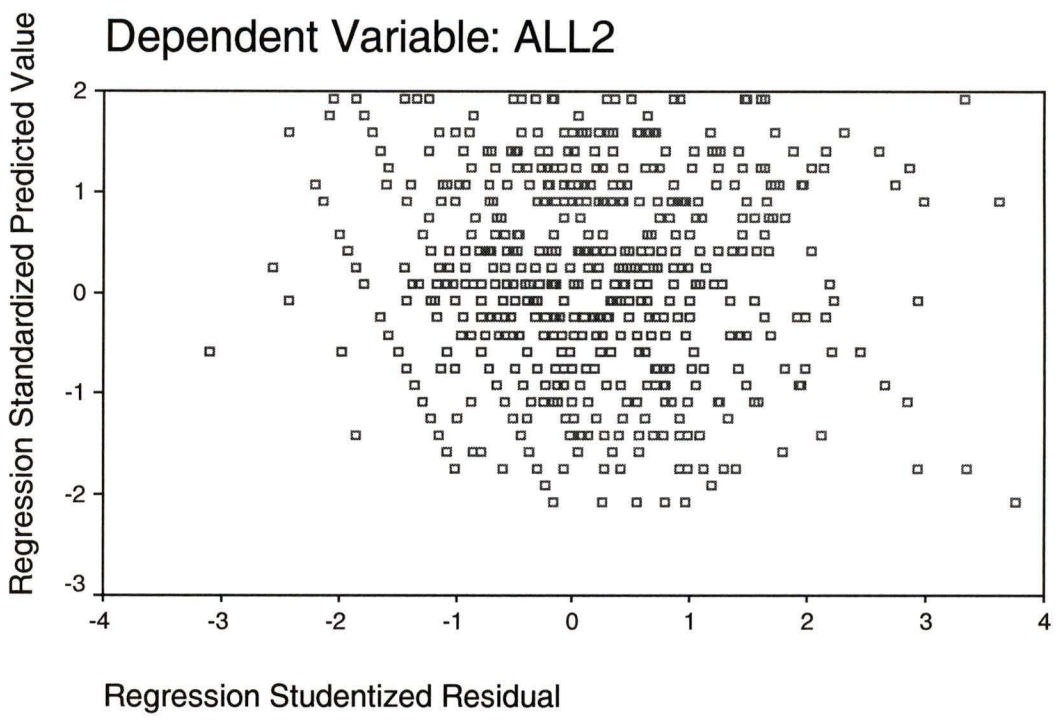


ADL

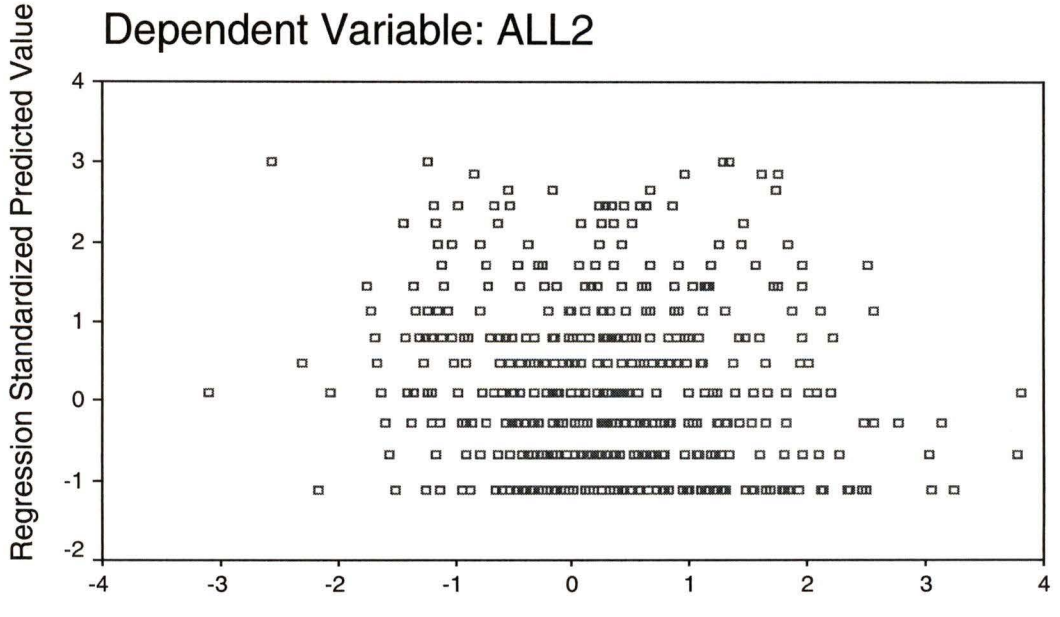
Dependent Variable: ALL2



IADL

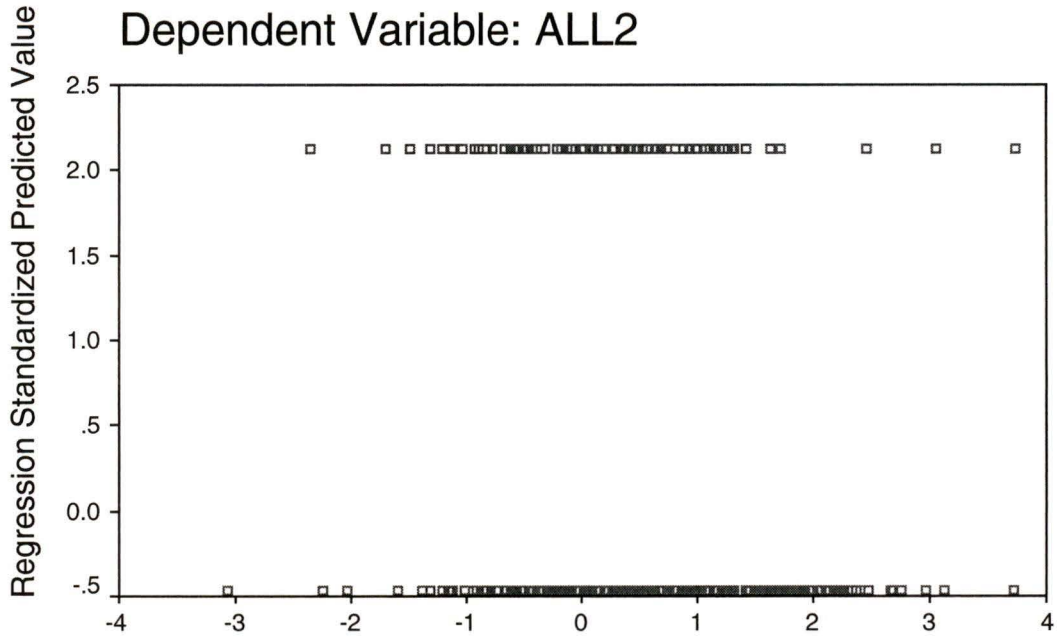

Dependent Variable: ALL2
Regression Standardized Predicted Value
2
1
0
-1
-2
-3
-4
-3
-2
-1
0
1
2
3
4
Regression Studentized Residual

MMSE


Dependent Variable: ALL2
Regression Standardized Predicted Value
4
3
2
1
0
-1
-2
-4
-3
-2
-1
0
1
2
3
4
Regression Studentized Residual

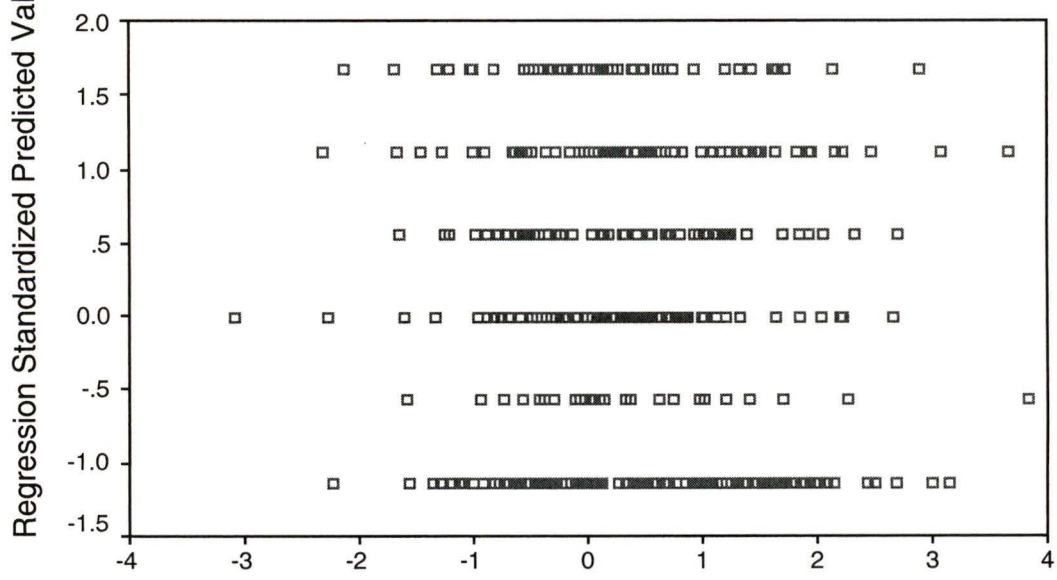
Gender

Dependent Variable: ALL2



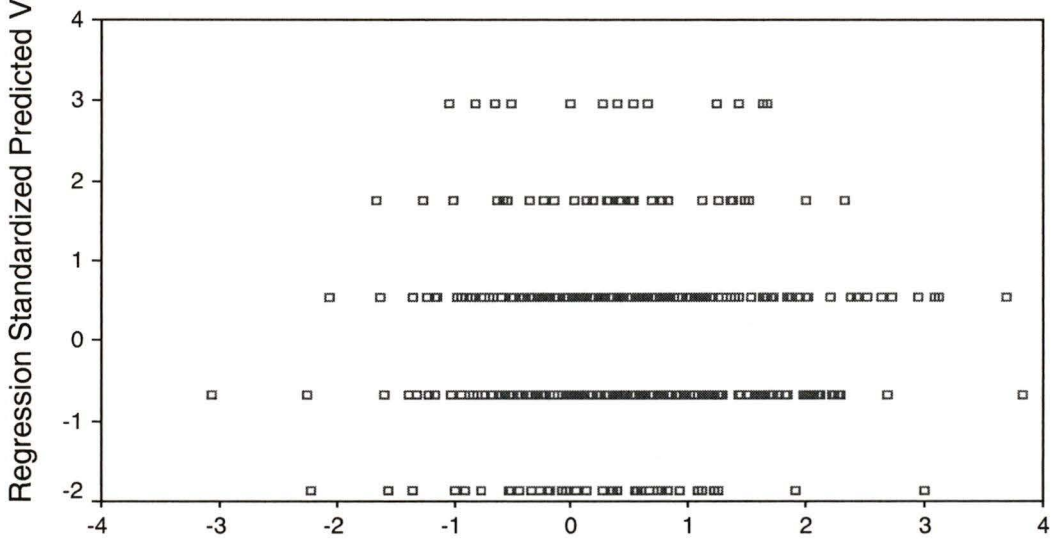
Class

Dependent Variable: ALL2



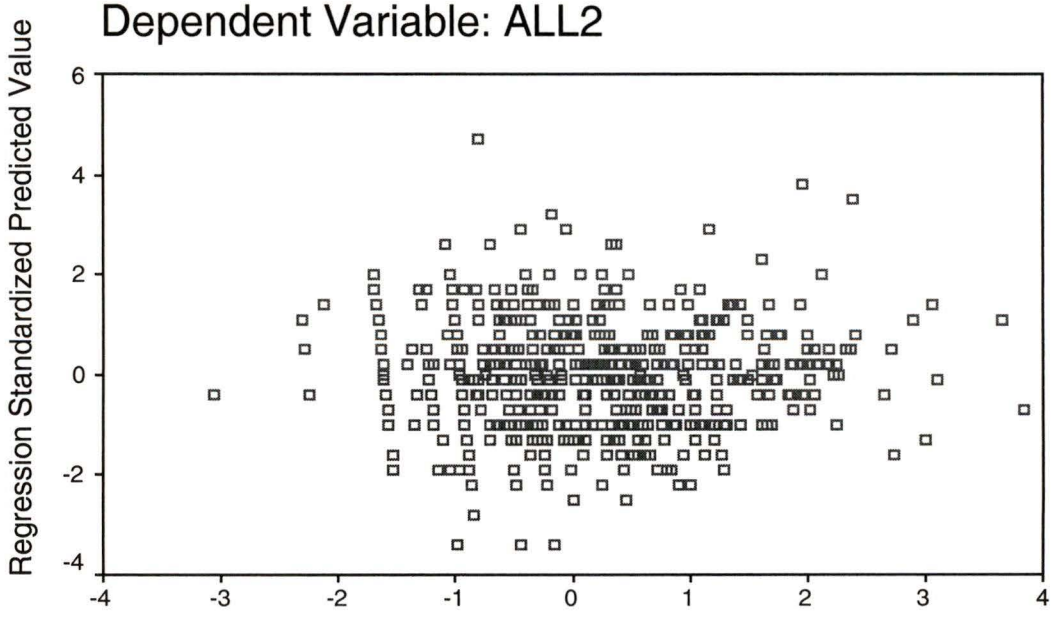
Income

Dependent Variable: ALL2



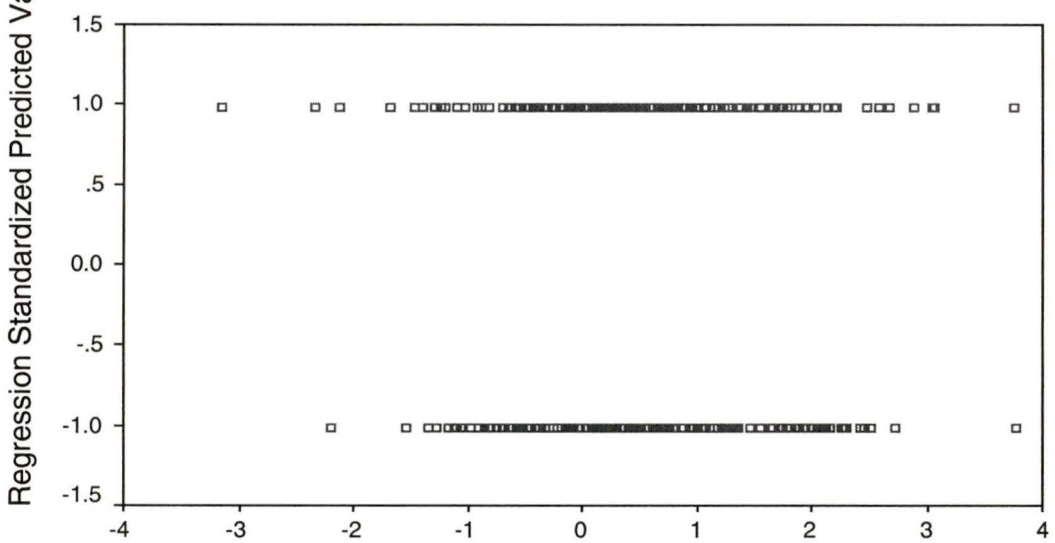
Education

Dependent Variable: ALL2



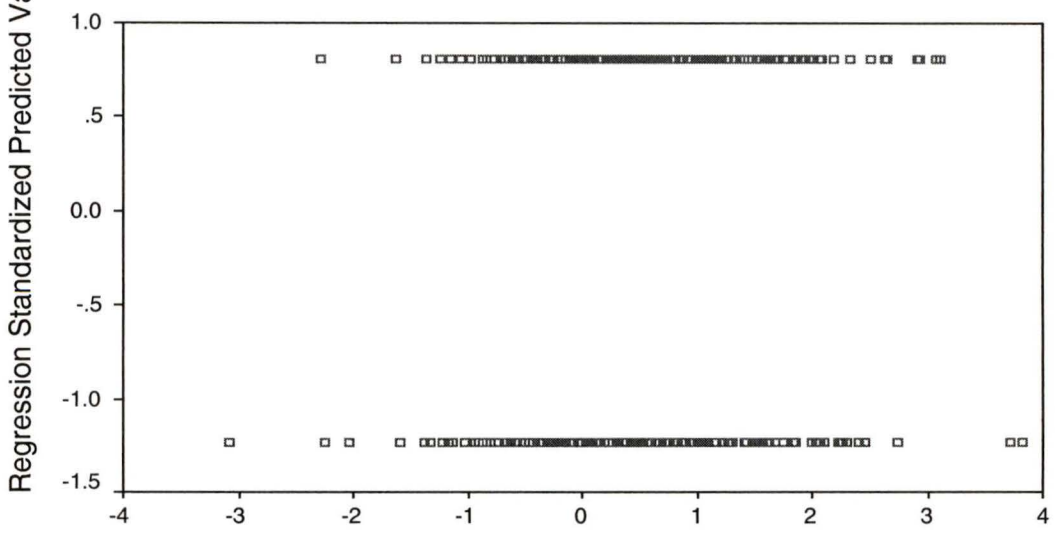
Home Ownership

Dependent Variable: ALL2

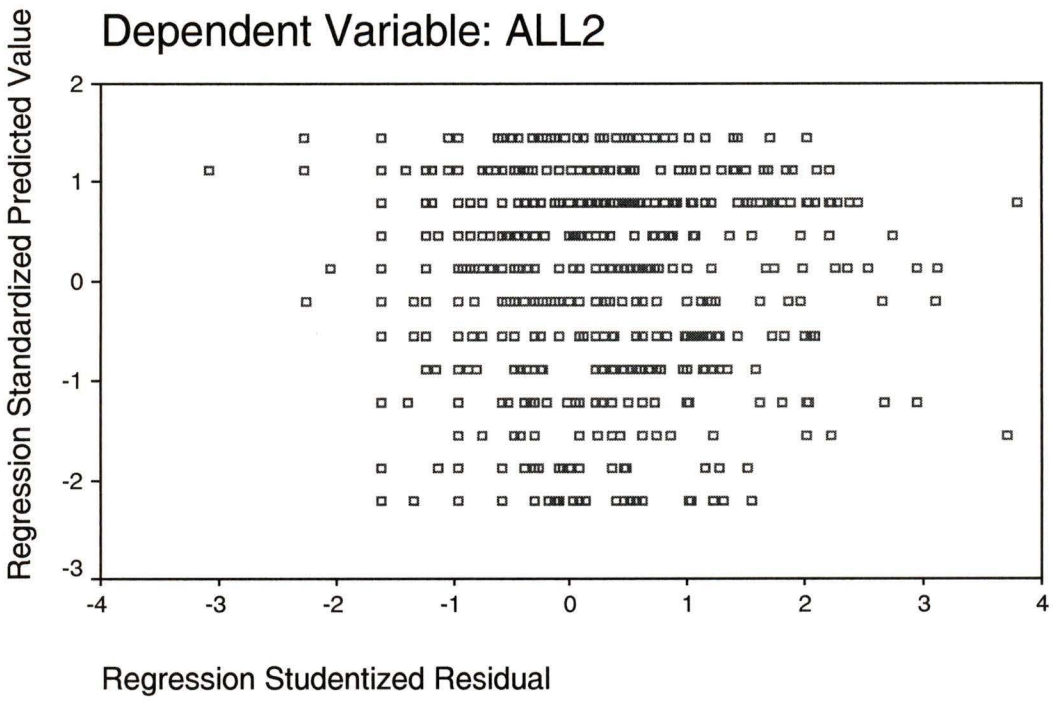


Assets

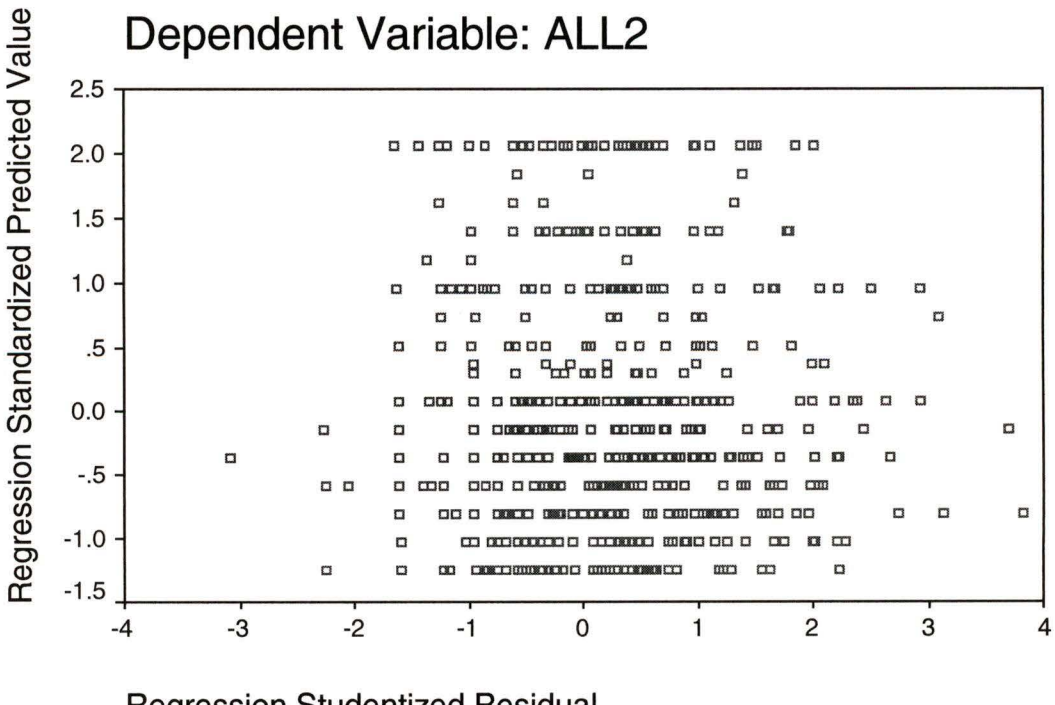
Dependent Variable: ALL2



Family

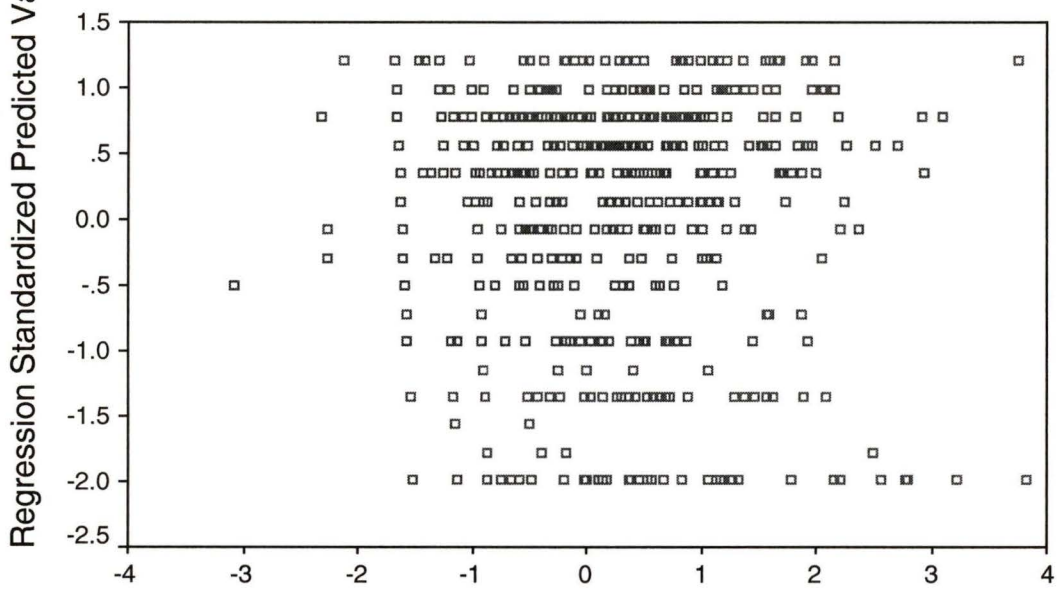


Friends



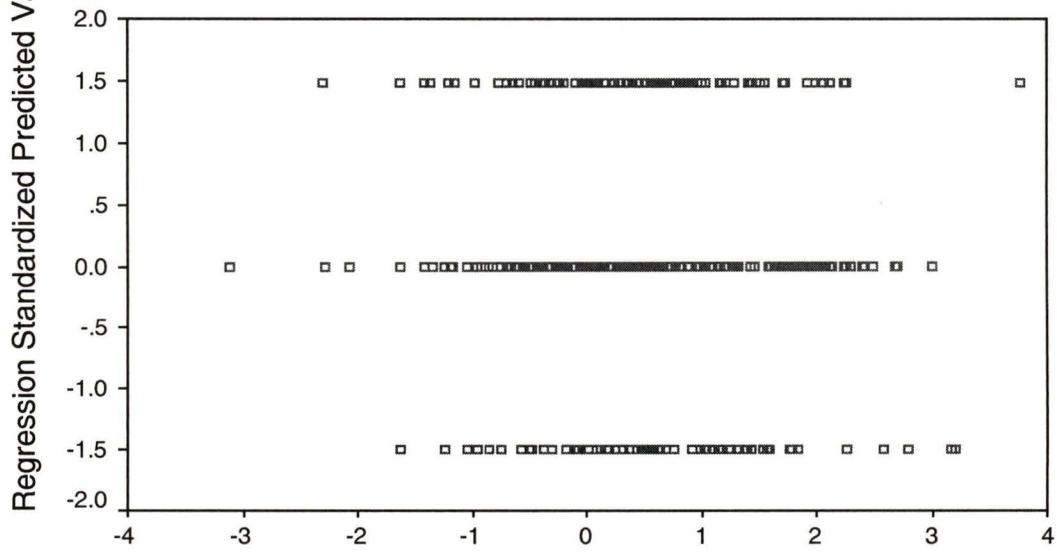
Others

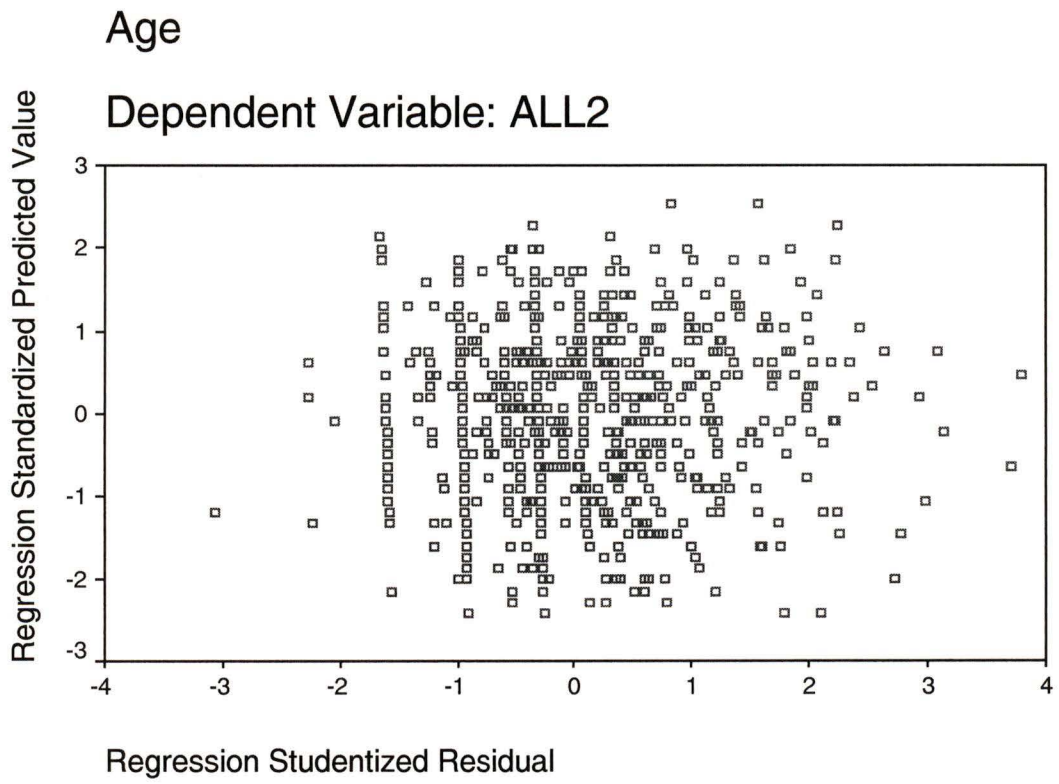
Dependent Variable: ALL2



Marital Status/Living Arrangements

Dependent Variable: ALL2




Age
Dependent Variable: ALL2
Regression Standardized Predicted Value
3
2
1
0
-1
-2
-3
-4
-3
-2
-1
0
1
2
3
4
Regression Studentized Residual

APPENDIX D

Table 32. Pearson Correlation Matrix of All Variables

	ADL	IADL	ADL1	MMSE	Gender	Class	Income	Educ.	Home	Assets	Family	Friends	Other	Age
IADL	0.597***													
ADL1	0.979***	0.624***												
MMSE2	-0.128**	-0.167**	-0.126**											
Gender	0.093**	0.034	0.107**	0.020										
Class	0.023	0.010	0.029	-0.076*	0.280***									
Income	-0.060	-0.146**	-0.079*	0.162***	-0.208**	-0.142**								
Educ.	-0.041	-0.109**	-0.041	0.260***	0.022	-0.213**	0.274***							
Home	-0.066*	-0.070*	-0.081**	0.018	-0.145**	-0.003	0.198***	0.119***						
Assets	0.034	-0.013	0.029	0.010	0.072*	0.037	-0.006	-0.026	0.051					
Family	-0.070*	-0.023	-0.077*	0.019	0.033	0.103***	-0.015	-0.089*	0.026	-0.050				
Friend	-0.086**	-0.120**	-0.093**	0.094**	-0.016	-0.026	0.174***	0.165***	0.120***	0.083**	0.011			
Other	-0.125**	-0.180**	-0.113**	0.138***	-0.008	-0.029	0.150***	0.173***	0.039	0.057	-0.030	0.291***		
Age	-0.002	0.057	0.021	-0.214**	-0.015	0.006	-0.104**	-0.071**	-0.108**	0.049	-0.171**	-0.008	-0.005	
Marital	0.080*	0.082**	0.100**	-0.050	0.220***	0.013	-0.300**	-0.085**	-0.246**	-0.043	-0.093**	-0.136**	-0.116**	0.097**
Extent	0.391***	0.389***	0.380***	-0.089*	-0.037	-0.041	0.025	0.044	0.064	-0.015	-0.004	0.012	-0.053	0.021

*Correlation is significant at the .05 level

**Correlation is significant at the .01 level

***Correlation is significant at the .001 level

APPENDIX E

Table 33. Collinearity Statistics

	Tolerance	VIF
ADL1	0.615	1.626
IADL	0.594	1.683
Gender	0.826	1.211
Class	0.852	1.173
Income	0.806	1.241
Assets	0.946	1.057
Own Home	0.880	1.136
Education	0.838	1.193
Marital	0.854	1.171
Family	0.521	1.920
Friends	0.342	2.924
Other	0.765	1.307
Social Network	0.252	3.966
Age	0.946	1.057

APPENDIX F

Table 34. Coefficient Scores for Type of Service Received by Gender, Class and Health Status

		B	Mean/Reference
Do not Receive any Service			
	Intercept	10.52367085	1
	Age	0.025284728	82.4279
	ADL	-2.153007024	2.313
	IADL	-0.269239695	16.93
	MMSE2	-0.000814773	368.4822
	Married/others	0.076950673	0
	Unmarried/alone	-0.776005929	0
	Men	0.005214775	0
	Professionals	17.21417888	0
	Managers and Technicians	0.012007178	1
	Skilled Labourers	0.029480868	0
	Semi-Skilled Labourers	-0.100102989	0
	Unskilled Labourers	0.431705064	0
Receive Home Support Services Only			
	Intercept	9.174339204	1
	Age	0.020105987	82.4279
	ADL	-2.728912626	2.313
	IADL	-0.075364415	16.93
	MMSE2	0.001880708	368.4822
	Married/others	-0.206972752	0
	Unmarried/alone	-0.415351019	0
	Men	0.257284197	0
	Professionals	17.03812109	0
	Managers and Technicians	-0.354201172	1
	Skilled Labourers	-0.188724333	0
	Semi-Skilled Labourers	-0.115974101	0
	Unskilled Labourers	0.497175433	0

APPENDIX G

Table 35. Coefficient Scores for Type of Service Received by Gender, Socioeconomic Position and Health Status

		B	Mean/Reference
Do not Receive any Service			
	Intercept	10.97272	1
	Age	0.027925	82.4279
	Education	-0.11485	11.2929
	ADL	-1.76882	2.313
	IADL	-0.26574	16.9327
	MMSE2	0.00027	368.4822
	Married/others	0.118652	0
	Unmarried/alone	-0.91265	0
	Men	0.111421	0
	Income of $9,000 or less	-0.43326	0
	Income $9,001 - $14,988	0.201349	1
	Income $15,000 - $29,988	-0.01647	0
	Rent from Other	-0.19798	1
	No Assets	0.054584	1
Home Support Services Only			
	Intercept	9.528608	1
	Age	0.020137	82.4279
	Education	-0.09108	11.2929
	ADL	-2.44938	2.313
	IADL	-0.08759	16.9327
	MMSE2	0.002784	368.4822
	Married/others	-0.16155	0
	Unmarried/alone	-0.4262	0
	Men	0.256742	0
	Income of $9,000 or less	-0.28027	0
	Income $9,001 - $14,988	0.026741	1
	Income $15,000 - $29,988	0.056101	0
	Rent from Other	-0.02914	1
	No Assets	0.234086	1

Table 36. Type of Service Received by Gender and Socioeconomic Position: Expected Probabilities by ADL Disability

	Do not Receive any Service	Home Support Services Only	Both Home Nursing and Home Support
5	95.19%	4.10%	0.70%
10	88.55%	9.22%	2.23%
15	82.39%	13.36%	4.25%
30	69.95%	17.75%	12.31%

Table 37. Type of Service Received by Gender and Socioeconomic Position: Expected Probabilities by IADL Disability

	Do not Receive any Service	Home Support Services Only	Both Home Nursing and Home Support
6	99.16%	0.71%	0.14%
15	92.50%	6.08%	1.42%
25	50.92%	37.93%	11.15%
30	23.38%	57.29%	19.33%

Table 38. Type of Service Received by Gender and Socioeconomic Position: Expected Probabilities by Cognitive Ability

	Do not Receive any Service	Home Support Services Only	Both Home Nursing and Home Support
5	89.53%	7.95%	2.52%
10	89.26%	8.28%	2.46%
20	88.32%	9.43%	2.25%
30	87.22%	10.84%	1.94%

Table 39. Type of Service Received by Gender and Socioeconomic Position: Expected Probabilities by Marital Status/Living Arrangement

	Do not Receive any Service	Home Support Services Only	Both Home Nursing and Home Support
Married/others	88.41%	9.32%	2.27%
Unmarried/alone	74.15%	20.51%	5.34%
Unmarried/others	86.78%	10.71%	2.51%

APPENDIX H

Table 40. Coefficient Scores for Type of Service Received by Gender, Class, Health Status and Informal Social Networks

		B	Mean/Reference
Do not Receive any Service			
	Intercept	9.359819	1
	Age	0.034044	82.4279
	ADL	-2.01674	1.609438
	IADL	-0.28093	16.9327
	MMSE2	-0.00089	368.4822
	Family	0.082103	5.5632
	Friends	-0.02154	5.7728
	Neighbours	0.00033	5.655
	Married/Other	0.072068	1
	Unmarried/Alone	-0.84572	0
	Men	-0.04309	0
	Professionals	17.30842	0
	Managers and Technicians	0.018628	1
	Skilled Labourers	0.072557	0
	Semi-Skilled Labourers	-0.09377	0
	Unskilled Labourers	0.477389	0
Receive Home Support Services Only			
	Intercept	9.409903	1
	Age	0.018417	82.4279
	ADL	-2.70237	1.609438
	IADL	-0.07428	16.9327
	MMSE2	0.001823	368.4822
	Family	-0.01795	5.5632
	Friends	-0.03012	5.7728
	Neighbours	0.027972	5.655
	Married/Other	-0.20973	1
	Unmarried/Alone	-0.44692	0
	Men	0.2184	0
	Professionals	17.03539	0
	Managers and Technicians	-0.40907	1
	Skilled Labourers	-0.24725	0
	Semi-Skilled Labourers	-0.15209	0
	Unskilled Labourers	0.499232	0

APPENDIX I

Table 41. Coefficient Scores for Type of Service Received by Gender, Socioeconomic Position, Health Status and Informal Social Networks

		B	Mean/Reference
Do not Receive any Service			
	Intercept	26.78498	1
	Age	0.030702	82.4279
	Education	-0.11726	11.2929
	ADL	-2.01059	2.313
	IADL	-0.28184	16.9327
	MMSE2	0.000523	368.4822
	Family	0.051142	5.5632
	Friends	0.006569	5.7728
	Neighbours	-0.00279	5.655
	Married/others	0.027567	0
	Unmarried/alone	-0.90084	0
	Men	-0.00208	0
	Income of $9,000 or less	-16.5424	0
	Income $9,001 - $14,988	-15.9907	1
	Income $15,000 - $29,988	-16.1595	0
	Income of $30,000 and greater	-16.4827	0
	Rent from Other	-0.15364	1
	No Assets	0.092097	1
Receive Home Support Services Only			
	Intercept	26.39958	1
	Age	0.013527	82.4279
	Education	-0.09917	11.2929
	ADL	-2.70343	2.313
	IADL	-0.07744	16.9327
	MMSE2	0.002939	368.4822
	Family	-0.04448	5.5632
	Friends	-0.00445	5.7728
	Neighbours	0.024261	5.655
	Married/others	-0.21014	0
	Unmarried/alone	-0.40697	0
	Men	0.186183	0
	Income of $9,000 or less	-16.1641	0
	Income $9,001 - $14,988	-15.9567	1
	Income $15,000 - $29,988	-15.925	0
	Income of $30,000 and greater	-16.3426	0
	Rent from Other	-0.01834	1
	No Assets	0.258278	1

Table 42. Type of Service Received by Gender, Socioeconomic Position and Informal Networks: Expected Probabilities by ADL Disability

	Do not Receive any Service	Home Support Services Only	Both Home Nursing and Home Support
5	21.5%	78.3%	0.2%
10	30.3%	68.3%	1.4%
15	35.6%	60.7%	3.8%
30	40.3%	42.5%	17.1%

Table 43. Type of Service Received by Gender, Socioeconomic Position and Informal Networks: Expected Probabilities by IADL Disability

	Do not Receive any Service	Home Support Services Only	Both Home Nursing and Home Support
6	71.9%	28.1%	0.0%
15	28.9%	70.9%	0.2%
25	5.0%	94.5%	0.6%
30	1.8%	97.3%	0.8%

Table 44. Type of Service Received by Gender, Socioeconomic Position and Informal Networks: Expected Probabilities by Cognitive Ability

	Do not Receive any Service	Home Support Services Only	Both Home Nursing and Home Support
5	38.4%	61.1%	0.5%
10	34.2%	65.3%	0.5%
20	20.2%	79.6%	0.2%
30	7.0%	92.9%	0.1%

Table 45. Type of Service Received by Gender, Socioeconomic Position and Informal Networks: Expected Probabilities by Family Members

	Do not Receive any Service	Home Support Services Only	Both Home Nursing and Home Support
1	15.0%	84.8%	0.2%
5	17.8%	82.0%	0.2%
9	21.0%	78.8%	0.2%
12	23.7%	76.1%	0.2%

Table 46. Type of Service Received by Gender, Socioeconomic Position and Informal Networks: Expected Probabilities by Marital Status/Living Arrangement

	Do not Receive any Service	Home Support Services Only	Both Home Nursing and Home Support
Married/others	21.5%	78.3%	0.2%
Unmarried/alone	11.6%	88.1%	0.3%
Unmarried/others	17.7%	82.1%	0.2%

APPENDIX J

Table 47. Coefficient Scores for Portion of Payment by Gender, Class, Health Status and Informal Social Networks

		B	Mean/Reference
Pay None	Intercept	1.597445	1
	Age	-0.03796	82.4279
	ADL	0.393358	2.313
	IADL	0.093344	16.9327
	MMSE2	-0.00165	368.4822
	Family	0.088798	5.5632
	Friends	-0.0563	5.7728
	Neighbours	-0.01459	5.655
	Married/others	-0.97145	0
	Unmarried/alone	-0.48021	0
	Men	0.108848	0
	Professionals	-1.05239	0
	Managers and Technicians	-0.42379	1
	Skilled Labourers	0.896554	0
	Semi-Skilled Labourers	0.711794	0
	Unskilled Labourers	1.792568	0
Pay Some	Intercept	5.321431	1
	Age	-0.07321	82.4279
	ADL	-0.5365	2.313
	IADL	0.106242	16.9327
	MMSE2	-0.00223	368.4822
	Family	0.018945	5.5632
	Friends	0.002209	5.7728
	Neighbours	-0.02843	5.655
	Married/others	-0.30314	0
	Unmarried/alone	0.202437	0
	Men	0.230932	0
	Professionals	0.485885	0
	Managers and Technicians	-0.27619	1
	Skilled Labourers	1.228889	0
	Semi-Skilled Labourers	0.518682	0
	Unskilled Labourers	1.46232	0

APPENDIX K

Table 48. Coefficient Scores for Portion of Payment by Gender, Socioeconomic Position, Health Status and Informal Social Networks

		B	Mean/Reference
Pay None	Intercept	-1.79175	1
	Age	-0.03945	82.4279
	Education	-0.11297	11.2929
	ADL	1.076765	2.313
	IADL	0.072534	16.9327
	MMSE2	-0.00026	368.4822
	Family	0.10552	5.5632
	Friends	-0.03687	5.7728
	Neighbours	-0.00608	5.655
	Married/Live with Others	-0.09956	1
	Unmarried Live Alone	-0.69232	0
	Men	0.759127	0
	Gross income of $9,000 or less	3.411167	0
	Gross income $9,001 - $14,988	3.717572	1
	Gross income $15,000 - $29,988	1.559134	0
	Rent from Other	0.413879	1
	No Assets	0.139719	1
Pay Some	Intercept	4.411631	1
	Age	-0.07366	82.4279
	Education	-0.03039	11.2929
	ADL	-0.2293	2.313
	IADL	0.09778	16.9327
	MMSE2	-0.0014	368.4822
	Family	0.022635	5.5632
	Friends	0.002736	5.7728
	Neighbours	-0.02275	5.655
	Married/Live with Others	-0.2797	1
	Unmarried Live Alone	0.011916	0
	Men	0.778405	0
	Gross income of $9,000 or less	1.050849	0
	Gross income $9,001 - $14,988	1.429603	1
	Gross income $15,000 - $29,988	0.523521	0
	Rent from Other	-0.09141	1
	No Assets	-0.028	1

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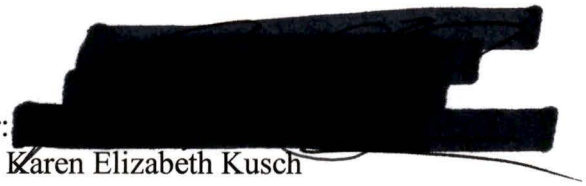
Author: 
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