''They suffered with us and should be compensated'': Entitling Caregivers of Canada's Veterans*

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RÉSUMÉ

L'article aborde la lutte de veuves d'anciens combattants pour obtenir l'admissibilité à vie à certaines prestations de soins à domicile du Programme pour l'autonomie des anciens combattants (PAAC) en reconnaissance des années de dispensation de soins non rémunérées, qui a abouti au changement de programme mis en œuvre de 2003 à 2004. Il illustre l'évolution de leur argumentation, de l'exposé sur la dépendance, les économies de coûts et la compassion à un discours sur l'admissibilité par droit et la commémoration dans la période de 1981 à 2004, alors que la majorité des anciens combattants de la Seconde Guerre mondiale et leur femme s'acheminaient vers la fin de leur vie. Cette victoire politique des veuves des anciens combattants marque un tournant historique dans le mandat du ministère des Anciens combattants et la reconnaissance par l'État de la prestation de soins familiaux non rétribués comme une forme de service pour le pays. Pour que cette victoire ait un rayonnement dans tout le pays cependant, les Canadiens devront considérer le labeur de la prestation des soins familiaux en général, pas seulement les soins dispensés par les veuves des anciens combattants, comme étant tout aussi héroïque et méritoire d'une rétribution.

ABSTRACT

This article examines the struggle to win lifetime eligibility for selected home care benefits provided through the Veterans Independence Program (VIP) for veterans' widows in recognition of their years of unpaid caregiving – a policy change eventually implemented between 2003 and 2004. It explores how arguments on their behalf shifted from discourses of dependency, cost-saving, and compassion to ones of entitlement and commemoration between 1981 and 2004 as the large cohort of Second World War veterans and their wives moved towards the end of their lives. This policy victory for veterans' widows marked a historic shift in mandate for Veterans Affairs Canada and an important recognition by the state of unpaid caregiving as a form of national service. If Canadians are to learn from this example, however, it must be through seeing all caregiving labour – not just that of veterans' wives – as equally heroic and worthy of compensation.

Since the mid 1980s the accelerating ''informalization of care'' by governments in response to the growing health costs of an aging society has sparked a wave of gerontological and feminist research on the rights and needs of unpaid and mostly female caregivers who are providing more than 80 per cent of all care given

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to the elderly (Hooyman & Gonyea, 1999). Writing in the *Canadian Journal on Aging*, Jane Aronson lamented her inability "to locate any Canadian studies of the extent of women's work in caring for old people" (Aronson, 1985, p. 117). Yet within a decade an explosion of books, articles, and special theme issues on the "mixed economy" of informal and formal care had become a focus in women's studies, social work, and social gerontology. Contributors to a *CJA* special issue in 1994 on the "caregiving dilemma" pointed out that "family caregiving has become a major theme in the literature on the provision of care to frail and ill older people" (Bornstein, 1994; Keating, Kerr, Warren, Grace, & Wertenberger, 1994, p. 269). Others have highlighted the "caregiving crisis" or "crunch" as *the* major issue facing all welfare states in the early twenty-first century (Myles, 1991). Summing up the state of this burgeoning literature in the *CJA*'s 2001 millennial issue, Neena Chappell and Margaret Penning nonetheless drew attention to a major paradox. The increased "recognition of the important role played by caregivers" had been accompanied by "simultaneous cutbacks to homemaking services" (Chappell & Penning, 2001, pp. 91–92), leaving community support services "the poor cousin in a mixed economy of care" (Neysmith, 1999, p. ii). The more that is known or recognized about the costs of unpaid caregiving to family members, it seems, the less governments are actually doing to provide help.

This disturbing policy disjuncture between recognition and assistance has prompted a heightened awareness of support for caregivers as a fundamental right of citizenship, particularly for women who, until now, have shouldered the overwhelming responsibility for the delivery of care (Aronson, 1990; Bornstein 1994; Hankivsky, 2004; Hooyman & Gonyea, 1999; Keating, Fast, Connidis, Penning, & Keefe, 1997). As a recent survey of the literature on family caregiving argues, "Promoting the carers' well-being has not been a policy goal, nor have caregivers' rights to public support been legitimized within long-term care policies. Instead, policies have focused on the dependent individual, not on the interconnections between the person with disabilities and those who provide care" (Hooyman & Gonyea, 1999, p. 162).

Over the past decade, however, one group of Canadians – bereaved caregivers of Canadian veterans, the overwhelmingly proportion of whom are women – have won important new rights for public support in recognition of their years of caregiving and the special status of those for whom they cared. Within a home care sector besieged by shrinking community-based support for the chronically ill, the Veterans Independence Program (VIP) for the past quarter century has stood out as a significant exception. Since its inception in 1981, the VIP has provided counselling, housekeeping, and home-maintenance services; personal care; respite; residential care; day care; social transportation; assistance with household alterations; medical supplies; and costly medical and equipment, albeit it to a select clientele. These are precisely the components of a "broad-based family approach" identified as essential to a "feminist model of care" (Hooyman & Gonyea, 1999, p. 162).

From the VIP's beginning, the importance of spousal caregivers to the program's success was acknowledged by policy makers within Veterans Affairs Canada (VAC). However, until 2003, this recognition did not extend to assisting veterans' wives in their own right following the death of their husbands. As Canada's Second World War veterans became increasingly frail near the century's end, the rights and needs of their wives took on heightened importance, sparking a growing debate among veterans' organizations, gerontological advisors to VAC, policy makers within that department, members of Parliament, and the media as to whether caregivers of veterans were themselves a direct responsibility of the federal government. What rights had *they* earned in exchange for their years of service? Was their continued ability to "age in place" with the help of VIP home care services dependent only on their partner's existence? Were spousal caregivers of veterans, as some members of Parliament argued, "war heroes in their own right?" (Canada, 2003, October 22, 2003, p. 8606-07; October 29, p. 8903-04; February 16, 2005). Or was their contribution in caring for veterans, at bottom, no more "heroic" than that of countless other family members providing unpaid care to Canada's aging population whose work might be deemed equally worthy of public recognition and support? Put differently, should the status of the care receiver determine the rights of the caregiver? Embedded within this debate lies an unresolved tension between the special debt owed to the carers of veterans and the larger claims of all caregivers of the elderly and disabled for adequate compensation and support if Canadian social policy is to be reoriented towards a broader "ethic of care" in the twenty-first century (Hankivsky, 2004).

Care and Cost-Saving: The Origins of the Veterans Independence Program

The VIP, Canada's national home care policy for veterans, was created in 1981 in response to two needs: the demographic aging of Canada's massive Second World War veterans cohort, over half of whom would reach age 65 by 1985, and Ottawa's previous promise to veterans that all who served overseas in

Table 1: Veterans Independence Program (VIP) chronology

April 1981	Aging Veterans Program, renamed the Veterans Independence Program (VIP) in January 1986, begins as a pilot project for war pensioners for pensioned conditions
October 1982	Housekeeping and/or groundskeeping services for veterans' widows continued for up to 30 days after spouse's death
August 1984–April 1989	VIP eligibility extended to War Veterans Allowance recipients, near-recipients, and Canada Service Veterans age 65 or over
September 1990	Housekeeping and/or groundskeeping services continued for the surviving spouse for up to one year
June 1991	VIP eligibility extended to Special Duty Area pensioners age 65 or over
June 1992	VIP eligibility extended to Merchant Navy Veterans age 65 or over
May 1993	Launch of Care for the Caregiver pilot project within Veterans Affairs
May 1997	Review of the Veterans Care Needs project
June 1997	First meeting of VAC Gerontological Advisory Council
June 2003	Lifetime housekeeping and/or groundskeeping services extended to qualified surviving spouses whose partners died after June 1, 2003
November 2003	Lifetime housekeeping and/or groundskeeping services made retroactive for qualified surviving spouses whose partners died after June 1990
February 2005	Lifetime housekeeping and/or groundskeeping services made retroactive for qualified surviving spouses whose partners died after 1981

Source: VAC, 2006.

either of the two world wars or the Korean conflict enjoyed a right to a long-term care bed, financed by the federal government. Faced with potential runaway costs for providing institutional care to an aging population at least two decades before Canada as a whole would need to do so, and under mounting pressure throughout the 1970s from a well-organized and vocal lobby of veterans' organizations to come up with policies to deal with their needs, VAC began to rethink new ways of delivering on its long-term care mandate. The result, in 1981, was the VIP.[1]

Although the stated focus of the program from its inception was promoting the dignity and independence of ''aging in place'' for veterans within their own homes and communities, its primary objective for Ottawa was to ''contain the increasing adverse effects of aging in Canada's veteran population more effectively and at reduced cost.'' Care in the home would ensure an ''improved and less costly response to the needs of individual veterans, offset risks of increased federal involvement in the operation of health care . . . and facilitate use of emerging provincial extended health care programs'' (Aging veteran, 1980, VIP). Since veterans' organizations viewed the guarantee of a long-term care bed as ''a virtual right, earned by contributions to the national interest in wartime'', reducing their reliance on this more expensive option, VAC officials argued, ''would likely be more acceptable if offset by . . . more use of community facilities and home-delivered services'' (Aging veteran; Background [1980?], VIP). A secondary objective, but one linked closely to the goal of cost-saving, was to ''maintain the self-sufficiency of a spouse whose marital partner requires extended in-patient care''. Since the wife was usually the veteran's primary caregiver, VAC officials realized early on that ''her health status is of concern to the Department'' (Aging veteran). Relieving caregiver burdens through contributions for home support or respite care was therefore in Ottawa's long-term interests.

Attention to the needs of the veteran's caregiver, therefore, began to emerge within the department almost as soon as the VIP was launched in 1981.[2] The first issue – one that would run like a thread throughout the entire history of the program – was whether veterans' widows should continue to receive home care services from the department after their husbands' deaths. Since the VIP was a needs-based health service targeted to the veteran rather than a war-related pension or allowance, there was no precedent within the pension ethic underpinning other veterans' benefits for a spouse to inherit any claim to it. When the veteran died, the VIP stopped immediately.

Within a year of the program's launch, however, VAC district counsellors began complaining that this abrupt cancellation was both harsh and unjust as it hit widows at the moment of their greatest need. As a result of protests flowing in from the field, in October 1982, a change was made, on compassionate grounds, to continue the VIP for up to 30 days after the veteran's death, although some officials cautioned

Table 2: VIP caseload and expenditure (5-year) intervals

Fiscal Year	Number of Clients	Expenditures ($ millions)
1985–1986	9,500	13.8
1990–1991	71,900	111.6
1995–1996	78,900	155.0
2000–2001	68,900	163.0
2005–2006	97,500*	274.0

* includes 25,000 widows who were primary caregivers of veterans

Sources: Veterans Independence Program Component Profile, p. 8, VIP; VAC, 2001, p. 17; VAC, 2006.

that even this modest concession might be the first step on a slippery slope that could lead "incrementally into the issue of health care for dependents, an issue that up to now has been avoided" (Boisvert, 1982, VIP; Hurley, 1982, VIP). Although the department acknowledged the "vital role of spouses in maintaining the well-being of entitled veterans", it rejected suggestions for including them directly within the widening circle of eligibility for VIP benefits when the pilot project phase of the program came to an end, and it was broadened to a much wider category of veterans between 1984 and 1989. Instead, department pronouncements reflected familialist assumptions dominant within Canadian society as a whole. "Members of the veteran's family and . . . his wife . . . are expected . . . to take a 'team' approach to family responsibilities including those with which the veteran is unable to cope", VAC Minister Bennett Campbell argued in making the case against any further extensions of VIP benefits to caregivers. "A 'family member' is a 'family member.' Society expects families to have ties and responsibilities and to accept these" (Campbell, 1983, VIP).

Care and Contribution: The Needs of Veterans' Wives

Between 1984 and 1989, as the increasingly popular VIP moved beyond the pilot project stage, its caseload grew dramatically, rising from 3,500 to over 40,000 by the decade's end. It would more than double again, reaching almost 88,000 by 1993 (VIP, [1995?], p. 8, VIP; VAC, 2001, 15). As larger numbers of aging veterans began to die, complaints from VAC field staff intensified about the failure to acknowledge the needs of their wives. This process was accelerated by the department's decision to provide gerontological training for its counsellors beginning in 1982 and to begin hiring younger university graduates with social work backgrounds who were more sensitive to needs-related concerns in order to replace an older field staff, frequently veterans themselves, who had viewed their job principally as enforcing the benefit and entitlement criteria of the veterans' Pension Act (Conrad, personal communication, July 9, 2003; Boisvert, personal communication July 8, 2003). As VAC officials pointed out, "whenever a counselor went into a veteran's home the interview was always with the veteran and the spouse. We ended up really recognizing that the contribution that caregivers made needed to be captured. So our . . . process was changed [in 1984–1985] to actually add an assessment component that took in the role that the caregiver was playing . . . . It gave us a picture of what the health of the caregiver in the home was, and also what the contribution was they were providing" (Conrad).[3]

Once counsellors were asked to document the key role of spousal caregivers while the veteran was alive, it was but a short step to underscoring the difficulties they faced once their partner had died and they suddenly found themselves cut off from further support through the VIP. "How can it be humanely rationalized that while the veteran lives we assist him in the care of his spouse, but after he dies we abandon her? The need for spousal assistance is much greater, generally, after the veteran dies than while he lived", some officials argued in the mid-1980s (Mackay, 1985, VIP). While acknowledging that the plight of veterans' widows posed a "difficult question", senior administrators disagreed that the department had any legal obligation or right to act, although they conceded there may well be a "moral responsibility" (Boisvert, 1985, VIP; Lindsay, 1985, VIP). The VIP had been created as an alternative to the *veteran's* right to a long-term care bed funded by the department. His wife had no such an entitlement. Her health needs were a provincial responsibility (Boisvert, 1985, VIP; Mogan, 1985, VIP).

Until 1988, debates around caregiver needs took place within VAC through the voices of counsellors working in the field as well as by some senior officials at departmental headquarters in Charlottetown. They did not come from veterans' organizations themselves, or from the media. Given the low level of interest in the costs of informal caregiving for the elderly generally throughout most of the 1980s, this is not surprising.[4] Because of the rapid expansion of its involvement in the lives of elderly couples across Canada through the VIP, VAC was "beginning to realize that caregiving was . . . a serious issue", as one gerontologist who worked closely with the department in the early 1990s pointed out. "They were really at the forefront of that. They were learning from the VIP. They were seeing situations in the home where the spouse, typically a wife, was caring for a husband . . . and they were seeing that caregiving piece emerge . . . They had the experience and data from their VIP program'' (interview, M. McClellan, December 19, 2003).

A detailed analysis of the VIP by Price Waterhouse consulting services between 1987 and 1988 confirmed that caregiving wives were central to the success of the program. Half of the VIP's clients had been admitted to a hospital over the past 3 years, 80 per cent were suffering from at least one chronic condition, and at least one-third could not be left alone. At the same time, only 35 per cent of their caregivers were rated by VAC counsellors as being in excellent or good health, and one-quarter were in poor health. This was a key finding, the authors of the study noted, since ''caregiver health status has implications for the amount and type of services needed by veterans to enable them to remain in their own homes [and] communities.'' Most clients, caregivers, and health professionals who were surveyed reported that the VIP had made a ''moderate'' or ''great deal'' of difference in reducing the caregiving burden, and 56 per cent of women caregivers themselves said that it had improved their own health. This was a finding of some importance. As the Price Waterhouse study argued, ''When the health of the caregiver is good, it can be expected that they will take on a variety of care activities on behalf of the veteran. If the health of the caregiver is poor, many of the care activities . . . will likely be transferred to the formal service system (Price Waterhouse, 1989, p. 40, VIP). Keeping the caregiver healthy, in other words, reduced the long-term cost of veterans' benefits to the state.

Care and Compassion: Extending VIP Eligibility to Widows for 1 Year

As the VIP entered into its second decade in the early 1990s, the needs and rights of spousal caregivers, which had lurked in the background of internal debates and studies within the department, emerged into the public spotlight. Three factors converged to provoke this result. The first was the lobbying by veterans' organizations. By 1989, almost all the male client groups who would win eligibility to the VIP had been brought within its framework through rapid liberalization of veterans' benefits during George Hees's tenure as minister of veterans affairs in the Mulroney administration.[5] As a result of these lobbying successes, organizations such as the Canadian Legion now began to turn their attention to the plight of veterans' widows, whose numbers were also growing as the average age of Second World War veterans crossed over age 70. On compassionate grounds, the Legion argued, widows should be given more time to make the difficult emotional and financial adjustment to the loss of their husbands. VIP home care services such as housekeeping and groundskeeping, which had assisted both the veteran and his wife to remain in their home, should be extended to widows for a full 12 month period rather than cut off after just 30 days. This would give the widow more time, if required, to seek out alternative living arrangements (Extend VIP, 1989, VIP; Extension of selected VIP benefits, 1989, VIP; Progress on the Veterans Front, 1990).

The Legion's request was met with sympathy within VAC but it also raised real concerns about setting a ''dangerous precedence'' that the veteran's spouse was indeed a client of the department, opening the door for arguments they should be entitled to other health benefits. Officials also warned, presciently as it turned out, that once such an extension of the VIP was granted, it would be ''difficult to terminate benefits after 12 months as the spouse is likely to become dependent upon the services.'' On the other hand, the numbers involved were not great. Widows of veterans getting VIP comprised only 2.5 per cent of the department's client population. Giving these 2,159 women an additional eleven months of housekeeping and groundskeeping support would cost only $2.1 million annually while generating a ''positive image for the Department in being sensitive to the needs of the veteran's family'' (Extension of selected VIP benefits, 1989, VIP; Conrad, 1990, VIP).

In the autumn of 1990 the government agreed to the change, but subject to the clear proviso that only the eligibility of the veteran, and not his wife, was being recognized, since housekeeping and groundskeeping were ''the only two aspects of VIP which also *indirectly benefit the spouse while being provided to the veteran*'' (Extension of all home care elements, 1990, VIP, my emphasis). The 12 month time limit was also critical for reinforcing the clear understanding that ''only the termination date of certain VIP elements is being extended . . . . Eligibility to a spouse is not being recognized; *eligibility still resides through the veteran*.'' The grounds for the policy change were compassion in order to ''help recently bereaved spouses get through a most difficult time'', not entitlement for years of caregiving (Extend VIP to surviving spouse, 1989, VIP, my emphasis; Canada, 1990, p. 15341).

Care for the Caregiver

The new fiscal climate of cost containment and program restraint that began to hit all federal government departments by the early 1990s and would endure until the late 1990s, as well as the advancing frailty of VIP clients – now on average 73 years of age – also highlighted within VAC the importance of "caring for the caregiver". Shortly after the Finance Department's new spending cutbacks rippled through the department, senior VAC officials observed that since informal caregivers were "critical for keeping veteran clients at home", it was essential for the department to "think about how caregiving issues can be built into our current VIP program". Faced with a "future of increasing clientele and steady or declining resources to address increasing need", strategies that could bolster informal care were essential in order to "meet the needs of the client population" (Conrad, May 18, July 8, 1991, VIP).

VAC officials who attended a two-day "Care for the Caregivers Conference" hosted by Mount Saint Vincent University (MSVU) in Halifax in the spring of 1991 came away from this event with a deeper perspective on the issue. MSVU had already trained a new generation of VAC counsellors in social work and gerontological skills. Department officials returned from the conference enthusiastic about what they had heard, particularly the need for greater focus on respite, support, and education for caregivers, and they were convinced their organization had to discover more about the "needs of our caregivers", the "gaps that exist", and the ways in which VAC could "link our policy on respite care to caregivers' needs". Regional directors were requested to forward data to department headquarters on the resources available to caregivers in their districts as well as the extent to which caregiver needs were being assessed. They were also asked to identify the greatest gaps in caregivers' programs in their area as well as the role VAC could play in meeting these needs. The information received was subsequently integrated into a discussion paper on "Care for the Caregiver" (Conrad, June 27, July 8, 1991, VIP).

The paper argued that although VAC had talked a lot about caregiver needs over the past few years, particularly in relation to the VIP, so far it had done "little . . . to formalize a program that recognizes and supports the caregiver". Five key gaps – client assessment, respite care, educational support, emotional support, and financial need – were singled out. Most districts, for example, reported that that "our major if not our only concern is the veteran." Assessing the needs of the caregiver was "not a part of the case management process." Instead, officials now argued, "a family-centred approach should be the focus" (Lougheed, 1992, VIP).

Since 1987, some respite care was being provided, but there were significant gaps. It was limited to only 1 month a year and was targeted more at the consequences rather than the prevention of caregiver burnout. Also, veteran caregivers providing support to their spouses were not eligible. Availability varied widely across the country and VAC had "not for the most part been proactive in encouraging the development of new programs." As for educational or emotional support for caregivers, the department had no strategies whatsoever beyond the informal advice and encouragement provided through district counsellors or nurses. If the department was serious about its commitment to keeping veterans in their homes as long as possible, it had to apply "energy and resources . . . in support of the caregivers of those veterans. Provision must be made to meet assessed needs not only of the veteran but of the caregiver. Support should include educational, emotional, and financial components as well as appropriate respite." These recommendations were "not . . . high cost items" but they did represent a "philosophical change in the concept of caregiving" (Lougheed, 1992, VIP; Respite for informal caregivers, 1992, VIP).

VAC's response was approval of a pilot project to identify caregiver needs, which would allow the department to develop a "purposeful caregiver support program, within the parameters of VIP, for nationwide implementation" (Conrad, 1992, VIP). As a first step, the department partnered with the Centre on Aging at MSVU on the development of an educational and training program on caregiver support for VIP staff and selected caregivers. The pilot project used training manuals, films, and workshop techniques adapted from the Centre's successful 3-year Care for the Caregiver project. "Many of our veterans now fall into [the] category of the 'frail elderly' population", VAC officials seconded to the project argued. "Much of [their] support is provided by Veteran's families, either the spouse who is herself aging and facing the lack of physical and emotional strength, or an adult child in her or his 50s or 60s and even 70s." Most of them had "very little experience in the area of caregiving to the elderly" and were often "overwhelmed by feelings of guilt, anger, failure, and confusion resulting from the demands of caregiving", leading to burnout or elder abuse. If they were to continue in their roles they "needed increased support" (O'Brien, 1992, VIP; Sampson, 1992, VIP; Darte, 1995, p. 1).

The Care for the Caregiver pilot project, under the direction of Marlene McClellan, a faculty member and project leader at MSVU, ran in both Edmonton and Ottawa regional offices of VAC between May and June 1993 (Care for the Caregiver, 1994, p. 16, VIP).[6] In all, 34 elderly caregivers (80% females and 20% males), ranging in age from 56 to 82 years, took part. Many were considered to be at high risk of physical, mental, and emotional exhaustion. They participated in a weekly series of six 2.5-hour workshops dealing with topics such as aging, stress management, growing dependency in the person they cared for, communication skills, and, perhaps most importantly, how to look after themselves, deal with their own feelings, and avoid burnout. They also were given practical information on respite and caregiving resources available in their region. A key goal of the project was to develop mutual aid and support (Care for the Caregiver, 1995, pp. 3–4, VIP).

As the sessions unfolded, the participants reaffirmed their high degree of satisfaction with the VIP. Indeed, the most commonly identified key contribution to caregiver support was assistance with housekeeping and groundskeeping – services they were already receiving through the program and were unavailable elsewhere. Without the VIP, the project's final report concluded, ''the veteran and/or his/her spouse would be in a long-term care institution and this would result in a major cost to the health care system'' (Care for the Caregiver, 1994, p. iii, VIP). The most important unmet need identified by the participants was more respite care. Almost 40 per cent of the participants reported receiving none whatsoever.

The project's key recommendations were: that VAC continue to develop educational and support sessions on caregiver support for clients and caregivers within the VIP; that it support further research and initiatives on assisting caregivers; that it provide training to staff, based on the needs identified in these areas; and that VIP clients be made aware of all forms of community support and assistance for caregivers. In a conclusion designed to appeal to policy makers preoccupied with deficit reduction, the final report also argued that care for the caregiver programs made good fiscal sense:

> In times of decreasing health care dollars, communities will be forced to rely more and more on the informal care system as a source of long-term care for the growing number of the frail elderly. The complexities of disabilities together with diminishing health resources from the provincial and community sector makes the informal care network worthy of development. The informal caregiver will more and more be viewed as a resource to maintain and/or increase the level of care provided to the frail elderly in their home. (Care for the Caregiver, 1994, p. 2, VIP)

However, this stress on ''cost containment'' was a double-edged sword since it came to be used as an argument against expanding the department's commitment to developing a national caregiver support program as suggested by VAC's 1992 discussion paper on the topic. The timing of the Care for the Caregiver pilot project in the early 1990s also coincided with a period when fiscal restraint pressures within both VAC and the federal government reached their peak. As result, senior officials worried that caregiver support programs were ''a 'slippery slope' [that] should be approached with caution'' (Hughes-Anthony, 1993, VIP). ''The question is cost . . . . Is this initiative an effective form of cost containment?'' they argued. ''Treasury Board would be open to new initiatives which, in effect, demonstrate ways to contain costs'' (Videoconference, 1994, VIP).

For the time being, VAC decided to hedge its bets. A few more pilot projects were approved in 1994 (Mogan, 1994), but the national implementation of a Care for the Caregiver program within VIP, recommended by the department's 1992 discussion paper, never materialized. ''Caregivers want support in the form of recognition'', senior officials concluded. ''It is not new programs that are required.'' VAC would ''share its expertise'' with provincial and municipal officials and voluntary associations in ''developing caregiver support programs. These approaches to delivery would have minimal costs to the Department'' (Rainville, 1994, VIP). But that was as far as the department would go.[7]

Care and Entitlement: Earning a Right to the VIP

From 1997 onwards, increasing attention to veterans' caregivers received prominence on three fronts: the Review of Veterans Care Needs (RVCN) project, the creation of a Gerontological Advisory Council for VAC, and testimony before the Senate Standing Subcommittee on Veterans Affairs. The RVCN project, created in October 1996 by the department, was a response to a new departmental philosophy of client-centred service delivery and the awareness by senior officials that in light of the widening age polarity of their clients, as younger Canadian Forces peacekeeping veterans joined the ranks of the traditional Second World War and Korean veteran cohort, ''the types of programs and services that were required needed to be changed'' (Conrad, personal communication, May 5, 2005).

In a series of 12 focus groups from across Canada, chosen from a random sample of aging veterans and their caregivers by the RVCN project team, the rights of veterans' wives emerged as the key unmet need. Participants sang the praises of the VIP and its importance in allowing them to continue living in their own homes, but as the authors of the 1997 RVCN report pointed out, ''the gap most often mentioned, without any probing, was entitlement for non-veteran spouses. There was strong objection to the lack of pension and health services for veterans' wives''

(VAC, 1997a, pp. 3–4). Veterans were ''most vocal on this issue'', arguing that they ''relied increasingly on a spouse as a 'team member' to maintain their independence''. They wanted VAC to address their question ''what happens to my spouse when I am dead?'' As another put it, ''If I pass away, my wife is out in the cold'' (VAC 1997a, pp. 4, 9, 13).

Their partners were equally concerned. Most had been providing care to their husbands for at least 5 years and ''felt they could not lead the social lifestyle they had previously . . . . They had adjusted their activities to meet the needs of their husbands, to be present, and to tend to the various needs which ranged from health to social needs . . . . Most were very proud of their ability to give care. Many were clearly at times overwhelmed by the responsibility'', and some ''did not know how much longer they could go on . . . . Physically, they were having great difficulties doing all that was required, and psychologically they were often very depressed . . . . They tended to believe that the veterans needed help, but that they, as caregivers, were not the ones who should ask for assistance.'' The project's final report on the focus group sessions also noted ''an undercurrent and unstated emotion of fear of what would happen to them should the veteran die'' (VAC, 1997a, 15, pp. 18–20, 22–23).

On this point, veterans' wives expressed a clear sense that their needs deserved respect and recognition, not out of compassion, but as direct compensation in exchange for service. They had *earned* continued support from the state in their own right, since ''it was often the combined capability of the caregiver and the veteran being able to share the maintenance responsibilities . . . which allowed the couple to remain at home.'' As one put it, ''We are the caregivers of veterans. They will give you service as long as the veteran is living. If he dies, what will happen to me? Will all those benefits be cut off?'' Others argued that ''their 'need' was a 'return' or 'compensation' for the commitment they made to their veteran spouses.'' The RVCN report concluded that, much like their husbands, ''these caregivers thought that the services available to their veteran spouses should also be available to them. Some felt strongly that, without their assistance as a caregiver, the costs of caring for the veteran would be much higher . . . . Thus, they rationalized the extension of veterans' services to include spousal caregivers.'' These women most adamantly did not want charity. ''They thought of community services as 'charity' and were less accepting of them because they were, as one participant said, 'very proud.''' The VIP, on the other hand, was ''acceptable to them because VIP is a service that they have earned'' (VAC, 1997a, pp. 22–23, 18, 34).

The creation of the Veterans Affairs Gerontological Advisory Council (GAC) in 1997 also provided a new and important vehicle for dialogue among department officials, veterans' organizations, and academic experts in aging and gerontology around the needs of veterans and their spousal or other informal caregivers. Until the formation of the GAC, veterans organizations and VAC had been engaged in a bilateral and frequently adversarial relationship around the response to veterans' needs. The insertion of a dozen academics twice a year into these policy debates, through the vehicle of the GAC, triangulated these discussions and allowed for some creative exchanges and coalitions to emerge (Keating, personal communication, 11 Dec. 2003).[8] As mentioned previously, throughout the 1990s gerontology in Canada and the United States had witnessed an explosion of research on caregiver issues. Now some of the leading Canadian advocates for the recognition and support of informal caregivers – Neena Chappell, Evelyn Shapiro, and Norah Keating – found themselves members of VAC's new advisory council (see Chappell, 1992; Keating, Kerr, Warren, Grace, & Wertenberger, 1994, pp. 268–287; Shapiro, 1997; Shapiro & Tate, 1985, pp. 11–19). Not surprisingly, one of the first suggestions they made in defining GAC research priorities was the topic of veteran spouses or caregivers. As Keating recalled,

> Part of the invitation to come on to the committee was that we really wanted to serve families. Veterans and their families were part of the mandate . . . I said, ''You know, as I'm understanding your programs and policies so far, they have been developed for veterans . . . [T]hey haven't really taken into account others.'' . . . And it was pretty clear where were the gaps. One of them was that if it's the veteran who is the client, then he gets all these services like VIP. And his wife may benefit from those, but once he's in residential care or dies, that's the end of any benefit for her. (Keating, personal communication, Dec. 11, 2003)

Within a year, Keating was chair of a working group on caregiving for the GAC, which explored, among other topics, the continuation of VIP after the death of the veteran (VAC, 1997b, p. 5). Leaders of veterans organizations and feminist gerontologists on the GAC quickly agreed on the need to enhance the rights of caregivers to VIP benefits. By 2000, the GAC had passed a motion, in response to the work of Keating's working group, recommending that ''the housekeeping and groundskeeping elements of VIP be extended to surviving spouses for life'' – a demand also being made by the Canadian Legion. Arguments in favour of even wider caregiver recognition were put forward in a major research report prepared for

VAC in 2001 by Keating and her colleagues Janet Fast and Jacquie Eales.

Unlike veterans organizations, Keating, Eales, and Fast argued for ''a policy of 'equal support for caregiving work of equal value''' that would recognize ''the full range of caregiving contributions within veterans' families.'' This approach would compensate not only caregivers *of* veterans, but caregivers who *were* veterans as well as caregivers of veterans not currently clients of the department. Under this framework, widowed spouses would receive eligibility for the VIP beyond 1 year. But they would also be eligible for a much wider range of veterans' health care benefits. Keating, Eales, and Fast also argued that VAC should financially compensate informal caregivers who had given up paid employment to provide care, and they called upon the department to move beyond a client-centred to a truly family-centred approach to meeting needs. ''Attempts to support caregivers with policies developed to support care recipients are cumbersome'', they concluded. As VAC began focusing on the veteran family unit, it should begin providing direct benefits to informal caregivers through existing programs such as the Veterans Health Care Regulations and Attendance Allowance previously targeted only to veterans. This was an ambitious policy agenda that included but went far beyond lifetime extension of grounds-keeping and housekeeping services of the VIP to widowed spouses of veterans (Keating, Eales, & Fast, 2001, pp. 1–2, 29–32).

Care and Commemoration: Honouring the Memory of Veterans

The debates on the needs and rights of veterans' caregivers within the RVCN project and the GAC took place beyond the public eye. This was not so within the Canadian Senate. Between 1997 and 2004 testimony before that body's Standing Sub-committee on Veterans Affairs became the most visible public arena in which the fight for recognition of veterans' spouses was played out. Throughout the 1990s the Senate sub-committee had played a key role in raising public awareness about the need for improved standards in veterans' health care (Canada, Senate, 1999). Beginning in 1997 the committee, under the leadership of Senator Orville Phillips, a distinguished Second World War veteran, turned its gaze towards the needs of veterans' wives. In January of that year, Phillips urged Canadian Legion officials to push more aggressively for caregiver rights. ''What about the widow who had cared for a veteran suffering from a stroke?'' Phillips asked. Without her labour ''it would have been necessary to place him in a home . . . and the department would incur some expenses . . . . The widow who has done all this extra work is entitled to some consideration after the death of the veteran who required care'' (Canada, Senate, 1997a).

In response to Phillips's prodding, the Legion, by the end of 1997, pressed harder for caregiver rights. ''We are not suggesting that the spouse should receive the equivalent of what her husband received'', Legion president Ralph Annis argued. ''All we are saying is that . . . in most cases . . . the spouse has taken care of that veteran for 50 years . . . . [T]hese spouses have done a lot of work for Veterans Affairs Canada and saved them money . . . [W]e believe that the spouse has hurt her own health. As a caregiver of long standing, that woman deserves some support.'' Cliff Chadderton, president of the War Amps of Canada, agreed. ''This is . . . a black mark on the government and on maybe even veterans' organizations who may not have fought hard enough on this issue . . . These are caregivers, most of them 50 years in the saddle. They could not go out and get jobs because they looked after their veteran spouses all those years. One year after his death she is cut off . . . . Certainly the Veterans Independence Program should continue for her life if she is capable of living in the house'' (Canada, Senate, 1997b).

In its March 1998 report, ''State of Health Care for War Veterans and Service Men and Women'', the Phillips sub-committee came out strongly in favour of extending lifetime eligibility for the VIP to veterans' widows. ''The Canadian people and government can no longer 'abandon' in old age the spouse who has spent decades looking after a severely disabled veteran with no more than a survivor's pension. While it is possible for them to remain in the home they should be entitled to the assistance of the Department.'' The senators also put a dollar value on caregivers' labour. ''Institutionalization of a seriously disabled veteran costs the Department $50,000–$80,000 per annum. This is the annual value to the government of Canada of the work and sacrifice of a spouse who tends to a disabled veteran in the home, sometimes over a period of decades'' (Canada, Senate, 1998).

By the autumn of 2001, winning lifetime eligibility to the VIP for veterans' widows had become the Legion's ''top priority''. Now that the average age of Second World War veterans was 81, the campaign had gained urgency and shifted rhetorical ground in some important ways. No longer was the core argument one of compassion for bereaved wives or compensation in exchange for caregiving – the argument favoured by veterans' wives themselves. Instead, the debate shifted to honouring and commemorating the sacrifices of veterans – a discourse that once again positioned spouses primarily as dependents of their husbands rather than as entitled caregivers. ''Certainly in the mind of the veteran, [the VIP] was taking care of both of them'', Jim Rycroft, the Legion's service director told the Senate committee that year. ''As the veteran contemplates his own passing, one of his primary concerns becomes what will happen to his spouse. We are trying to honour the veteran's wishes to take care of the surviving spouse. That is the proper thing for Canadians to do'' (Canada, Senate, 2001).

Until 2003, the Chrétien Liberal government, although sympathetic to the contributions and the plight of veterans' widows, had resisted all arguments in favour of granting them lifetime eligibility for VIP services, because of what this change might imply about who were the ''real'' clients of Veterans Affairs. On May 12 of that year, VAC Minister Rey Pagtakhan, however, announced suddenly in the House of Commons that his department would soon ''bring forward legislation . . . to address the most urgent needs of Canada's Veterans as identified by the national Veteran's organizations.'' At the top of his list of changes was lifetime continuation of VIP grounds maintenance and housekeeping services for surviving spouses of veterans. The language of Pagtakhan's speech underscored the new hierarchy of the arguments underpinning this major shift in the department's mandate. These changes, he argued, ''offer Canada an opportunity to further express our nation's unending gratitude to our Veterans . . . [They] *also* recognize the value of lifelong caregiving that has been provided to Veterans with disabilities by their spouses'' (VAC, 2003, my emphasis). In thanking Ottawa for meeting its ''number one priority'', the Legion's president reinforced this same commemorative rationale. ''The Royal Canadian Legion welcomes this positive development in ensuring that the sacrifices of Canadian Veterans will not be forgotten'' (VAC, 2003).

This abrupt policy reversal surprised even senior VAC officials. ''I really don't know how I account for it, to be honest with you'', one recalled. ''Had you asked me last year whether or not we would be actually doing this, I would have bet my paycheck that we wouldn't . . . [Because] once you open the gate and say, yes, we recognize that the spouse, who is a non-veteran, should have this entitlement . . . well, why not others?'' (Conrad, personal communication, May 5, 2005). Certainly, pressure from veterans organizations and the department's own gerontological advisory council contributed to the decision. So too did the fact that the policy change was for the most part revenue-neutral, given the rapid attrition of Canada's Second World War veteran population (Conrad, 2005). Above all, the political timing was right. In 2005, Canada would celebrate the sixtieth anniversary of V-E Day. At the same time, the average age of Second World War veterans and their spouses would hit 84. These two realities made for a potent combination. As this same VAC official conceded,

> The reason [the veteran] has been able to exist for so many years independently in his own home, is because he's had a spouse that has been there day in and day out providing the caregiving at no expense to the department. And you also have a veteran who we need . . . to recognize and commemorate the contribution that this person has made and to leave a legacy for the young people of Canada . . . . So there is a definite linkage there. (Conrad, 2005)

Care and Discrimination: Creating Two Classes of Veterans' Widows

Ironically, the Chrétien government unwisely underestimated the power of this linkage by deciding not to make veterans' widows' eligibility for the VIP retroactive. Instead, only those wives whose husbands died subsequent to Pagtakhan's May 12, 2003 announcement benefited from the change. The arbitrary nature of this cut-off point quickly provoked a firestorm of criticism that caught the government and leaders of veterans organizations by surprise. Once again, the intense emotional power of commemoration, as Canada approached the sixtieth anniversary of V-E Day, played a key role. ''What we are doing here is setting up two classes of veterans' widows'', Conservative and Alliance members of Parliament argued vehemently. ''If a veteran died on May 11, 2003 his widow would only receive VIP benefits for one year. If he lived one more day, she would receive the VIP benefits for the rest of her life. This is entirely unfair . . . . This is not taking care of those who have taken care of our national heroes . . . . It dishonours their memory by mistreating their loved ones . . . [T]hese brave women are heroes in their own right'' (Canada, October 22, 2003, pp. 8606–07).

The media quickly picked up this same refrain. The *National Post* launched a series of articles throughout 2003 and 2004 publicizing the efforts of Joyce Carter, a 77-year-old Nova Scotia grandmother and veteran's widow, to win equal treatment for all surviving spouses of veterans. ''A veteran's widow is a veteran's widow. Why discriminate? It's unforgivable'', Carter argued (War widows in new battle, 2004). ''We're not looking to get rich. We're just looking to survive and get things we need . . . . A lot of widows have to leave their homes because they don't have the money to maintain it'' (Advocate for vets' widows, 2004). As another woman put it, ''I cared for my husband, who had dementia, at home the last four years of his life . . . . He was on the VIP when he passed away April 27 1990. I feel he earned everything he ever received from Veterans Affairs. I feel as does everyone I've spoken to, that I have earned the VIP by caring for my husband for over 45 years. This is the worst case of discrimination anyone has ever heard of in Canada'' (cited in Canada, October 22, 2003, p. 8608). Even backbench Liberal MPs termed the decision ''repulsive'' and ''niggardly'' (War widows get help, 2003).

After what was described as an ''emotional'' caucus meeting in October 2003, Chrétien promised he would correct the injustice (War widows get help, 2003). On November 6, 5 days before Remembrance Day, conceding that the issue was ''very much in the media'', Pagtakhan announced that widows' eligibility for the VIP would be made retroactive to 1990, when benefits to spouses were first extended from 30 days to 12 months after a veteran's death. Over 23,000 additional women would become eligible for support at an estimated cost of $170 million over the next 5 years (Canada, Senate, 2003; Vets' widows to get benefits, 2003). Even this decision proved insufficient. Pressure continued over the next year from veterans' wives, led by Joyce Carter, newspapers such as the *National Post*, the Senate Sub-committee on Veterans Affairs, and backbench members of Parliament, to include the remaining 4,000 widows of veterans whose husbands, in receipt of the VIP, had died or subsequently been institutionalized between 1981 and 1990. Most of these women were older and even more in need of the VIP's support to remain in their homes.

On December 7, 2004, Albina Guarnieri, Pagtakhan's successor as minister of veterans affairs in Paul Martin's new Liberal government, conceded the point. ''Voices from across Canada'', she told the Senate Sub-committee on Veterans Affairs, ''have spoken on behalf of [these] 4,000 additional primary caregivers who are still not included in the program, but had at one time cared for a veteran and received VIP services.'' They too would retroactively be granted lifetime eligibility to the housekeeping and groundskeeping services of the program their partners had previously enjoyed before their death or entry into a long-term care facility – a decision anticipated to cost the department an additional $31.7 million over the next 5 years. ''We felt they were essentially unpaid partners of Veterans Affairs who were helping us care for our veterans. They deserved our support in their declining years'', Guarnieri argued (Canada, Senate, 2004; Rules changed, 2004). Like her predecessor, the VAC minister also linked the decision to Canada's mandate of commemoration in 2005:

> To help thousands more surviving caregivers stay in their homes longer with a higher quality of life is our way of caring for those who gave so much care to our veterans. It was simply the right thing to do . . . . The Year of the Veteran will be a national history lesson, a national show of gratitude for our veterans and an opportunity to renew our commitment to remembrance and pass that tradition on to a new generation. (Canada, Senate, 2004)

These decisions, taken between May 2003 and December 2004, marked a historic shift in VAC's mandate. For the first time in its history, not simply male service in time of war, but women's caring in time of peace was acknowledged as conveying a lifetime right to assistance for living independently in the community.[9]

Conclusion

What lessons can be drawn from this case study of recognition and limited entitlement of spousal caregivers of veterans for wider debates surrounding the rights and needs of other caregivers across Canada? Does the victory of veterans' widows in gaining lifetime eligibility to selected aspects of the VIP have any relevance to the needs of an estimated 2.6 million Canadians, overwhelmingly women, providing unpaid help to individuals with long-term health problems (Report to the Annual Premiers Conference, 2002, p. 17). Veterans enjoy a special historical relationship to the state. Policies derived from their wartime sacrifice may in fact obscure linkages between the right of their spouses to receive care in return for years of giving care and the needs of others doing similar work among the wider population. As Theda Skocpol has argued elsewhere, policy victories gained through the logic of ''legion populism'' and targeted to ''the deserving core of a special generation'' do not always translate well into claims easily winnable by a wider public (Skocpol, 1996, 1992).

With respect to thinking about the rights of caregivers, this would be a mistake. The sacrifices endured by Canada's Second World War veterans were unique. The care dilemmas they and their spouses faced as they grew old were not. Indeed, the inspiration behind the provision of groundskeeping, housekeeping, social transportation, respite, and personal care services available through the VIP were derived from British models of social care for the elderly, which did not originate with veterans in mind (Struthers, 2004, pp. 5–18; Thane, 2000, pp. 443–453). If adopted nationally, programs like the VIP would allow a much wider cohort of aging and disabled

Canadians to live longer in comfort and dignity in their homes. Instead, Canadian policies are moving in the opposite direction. Over the past decade, while entitlements of older veterans and their caregivers have expanded, other Canadians, as Jane Aronson points out, have experienced a "withering of long-term, supportive home care" through a process that has occurred "with remarkably little public debate or transparency" (Aronson, 2004, p. 168). According to one recent Statistics Canada study, over 839,000 aging Canadians with chronic care needs who require health-related care in the home are not getting it (Henderson, 2002, p. 281).

In the struggle for recognizing caregiver rights within the VIP, advocates argued passionately and ultimately successfully against the creation of "two classes of veterans widows". A similar logic applies to ending discrimination against caregivers generally. The moral claims of veterans' widows for recognition and entitlement, in return for caregiving, apply to all unpaid carers of the elderly and disabled, of injured workers, and of clients of provincial continuing care and rehabilitation programs across Canada. In these sectors, compensation and support are still overwhelmingly "aimed at the people who need the care, not those who look after them" (Canada lags behind, 2005). Australia, the United Kingdom, Germany, Japan, and the Netherlands have developed national programs or strategies entitling caregivers to receive care and compensation in recognition for their work (Canadian Caregiver Coalition, 2004).[10] Canada's belated recognition of the rights and caregiving contributions of veterans' wives will be a divisive step if it does not help to move us towards a broader "ethic of care" in which adequate support for all carers is seen as a fundamental right of citizenship (Hankivsky, 2004, 125).

Notes

1 Until 1986 it was called the Aging Veterans Program (AVP).

2 One of the first examples was the use in 1981–1982 of a 12-part Canadian Red Cross film series for training family members in home care, entitled *There's No Place Like Home for Health Care*. It began by noting that Canada's health-care system was "already overburdened" and required a "new and exciting focus .... That's why home health care is of increasing relevance." Film 4 in this series taught caregivers how to "record the physical and emotional state of the care receiver". No mention was made of the physical and emotional state of the caregiver (St. John's Ambulance [1980–1981?]).

3 VAC's decision in 1984 to direct its VIP area counsellors to begin documenting caregiver contributions in their assessment reinforces Emily Abel's observation that "by analyzing the chores caregivers perform, researchers have demonstrated that informal caregiving is labour-intensive. Family members shop for elderly persons, dress them, cook their meals, help them in and out of bed, and administer their medications. Viewing caregiving in this way has made it easier to recognize that informal care is socially necessary work and has an important place in the long term care system. The gerontological literature thus inadvertently contributes to the feminist project of revaluing women's work at home" (Abel, 1991, p. 60). One might argue that, after 1984, VAC was also "inadvertently" contributing to this same project.

4 Abel observed that "although caregiving is predominantly women's work, care for the elderly is largely absent from the feminist agenda in the United States" (Abel, 1991, p. 6). This situation would change rapidly in the 1990s.

5 War Veterans Allowance (WVA) veterans won eligibility for the VIP between 1984 and 1985; WVA "near-recipients" (those who would have been on WVA except for their eligibility for Old Age Security) won eligibility by 1988; and Canada Service Only veterans gained access to the program in 1989. As a result, the VIP caseload jumped from 5,500 veterans in 1984–1985 to 71,900 by 1990–1991, and would peak at 87,900 in 1992–1993. Merchant seamen and special duty area pensioners would gain eligibility between 1991 and 1992.

6 The final report noted that "the objectives for the staff education or training were not so clearly met .... The manual and videos were considered to be too basic and elementary" (Rainville, 1994, pp. 18–19, VIP). Since the participating VAC staff were all highly trained in social work or gerontology, they wanted less information on ageing and more on the skills needed to implement and facilitate workshops.

7 By giving a high profile to the issues of caregiver burnout, support, and recognition, Veterans Affairs Canada was one of the first government agencies in Canada to publicize and support research on an issue that would explode in importance during the decade ahead. By making the training manuals and videotapes of the project available to organizations across Canada and around the world, VAC also helped to get the message out about the highly gendered costs and consequences of informal care for the elderly. Today a newly revised 2002 version of the Caregiver for the Caregiver series is available online from the department's website (VAC, 2005). For a critique of caregiver support group programs, see Abel, 1991, p. 60; Aronson, 1990, p. 236; Lavoie, 1995.

8 In the United States, the Veterans Affairs Administration in 1980 had formed a similar Geriatrics and Gerontology Advisory Committee, composed of "outside experts in the field" (see Achenbaum, 1995, p. 235).

9 As of the end of October 2006, Joyce Carter was still publicly lobbying the new Conservative government of Stephen Harper for the inclusion of veterans' widows into the VIP who were disqualified either because their

husbands had died before the program was launched in 1981, or because they had never applied for it. Prior to the 2005 national election, Carter claimed, Harper had promised her in writing he would make such a change, if he formed the next government. ''When I started this I started it so that every widow could receive it. And I am going to continue to fight them until they do it. This is a promise that Stephen Harper made'' (Veterans' widows still waiting, 2006).

10 Canadian caregivers are eligible to a maximum of $605 a year in tax relief, along with short-term paid work leave for palliative care. Employment Insurance will pay up to 55 per cent of salary, to a maximum of $413 per week for 6 weeks to immediate family members of the ill, but only a small percentage of those eligible for the benefit have been able to claim it. Australia pays caregivers $90 a week, and low-income caregivers may receive $460 every two weeks (Keefe, 2004a, 2004b).

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