The ethics of care and the Newfoundland Paid Family Caregiver Program: An assessment

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Acknowledgements

The author wishes to thank Fiona Robinson, Lisa Mills, and Christine Koggel for extremely helpful comments on an earlier draft of this paper. This article also greatly benefited from the comments and suggestions of the two peer reviewers. Finally, special thanks to Kate Bezanson for exceptional editorial support.

Funding Acknowledgement

This work was supported by Social Sciences and Humanities Research Council of Canada [grant number 767-2015-1242].

Fitzgerald Murphy, M. (2017) The ethics of care and the Newfoundland Paid Family Caregiver Program: An assessment. Canadian Review of Social Policy/Revue Canadienne de Politique Sociale, Issue 77, Summer/Fall 2017, pp 1-16.

Abstract

The ethics of care has gained traction as a feminist normative lens from which to examine policies and policy issues (Hankivksy 2004; Mahon and Robinson 2011; Sevenhuijsen 2003; Sevenhuijsen et al. 2006). This paper aims to contribute to this growing literature by employing a critical ethics of care lens to assess a long-term care initiative in the province of Newfoundland and Labrador, Canada. This initiative, called the Newfoundland Paid Family Caregiver Program (NPFCP), allows eligible participants to pay family members for some care services. This analysis uncovers numerous tensions, both practical and theoretical, related to the way this program (re)shapes the caring relations of participants. Specifically, the paper discusses the ways in which this program downloads caring responsibilities onto the family, characterizes care as a private concern, and fails to facilitate competent and consistent care.

Keywords: critical ethics of care; long-term care; direct funding programs; normative policy analysis

Résumé

L'éthique du care (voir aussi éthique de la sollicitude) a gagné en popularité en tant que notion féministe qui examine les politiques et les enjeux politiques (Hankivksy 2004; Mahon and Robinson 2011; Sevenhuijsen 2003; Sevenhuijsen et al. 2006). Cet article a pour but de contribuer à cette littérature grandissante en abordant l'éthique du care d'un œil critique afin d'interpréter l'initiative de soin de longue durée dans la province de Terre-Neuve-et-Labrador au Canada. Cette initiative, appelée Newfoundland Paid Family Caregiver Program (NPFCP) est un programme permettant aux participants admissibles d'obtenir des soins rémunérés d'un membre de sa famille. Cette analyse décèle de nombreuses tensions, pratiques et théoriques, liées à la manière dont le programme redéfinit la sollicitude des participants. Plus précisément, cet article aborde la façon dont ce programme transfert la responsabilité des soins à la famille, traite les soins comme une affaire privée et ne facilite pas les soins professionnels et continus.

Mots clé: Éthique du care crucial ; soin de longue durée ; programmes de financement direct ; analyse normative des politiques

Introduction

The province of Newfoundland and Labrador is facing significant challenges in terms of the provision of long-term care for the elderly population. Critical gaps in long-term care services, particularly in rural areas, have resulted from a combination of factors, including shifts in demographic patterns, out-province migration, the decay of the traditional male breadwinner model, and ongoing cuts in social services (Botting, 2001; Government of Newfoundland, 2012). In response to this problem, the provincial Conservative government initiated a program allowing eligible home support clients to pay family members for some personal care and behavioural support services. This program is called the Newfoundland Paid Family Caregiver Program (NPFCP). The pilot project for this program commenced on March 24, 2014.[1]

This paper examines the NPFCP using a critical ethics of care lens. What is uniquely 'critical' about the ethics of care as used in this analysis is that it emphasizes the importance of locating care within the context of the wider institutions and structures which shape the global order; understood in this way, relational thinking can assist us in exposing the often hidden values and norms which reinforce and reproduce established exclusionary social practices and attitudes. [A critical ethics of care] attempts to show that, when taken as part of a larger, critical-relational approach to moral exclusion, care transcends its perceived limitations as an ethics which is relevant only in the context of physically and emotionally close personal relationships (Robinson, 1999, p. 110-1).

The analysis put forward here reveals several salient points about this program. It highlights how this program is (re)shaping caregiving, care receiving, and care work by allocating the responsibility for care to the family and (back) into the private sphere. This, it is suggested, indicates that the program works to perpetuate the characterization of care as a private concern. This normative and critical assessment of the NPFCP also explores the consequences of the targeted structure of the program. Lastly, the analysis illuminates how the program fails to consider the wider contexts, including systems of oppression, domination, and exploitation, in which all relations of care reside. This is problematic, for we do not have a full account of people's caring needs if we abstract them from their relationships and circumstances. Based on these issues, the paper concludes that the NPFCP may be failing to facilitate quality, competent, consistent care, and calls for further research in order to explore the consequences of such failures.

Finally, before proceeding to the analysis, a note on normative policy analysis is necessary. There are several approaches to policy analysis; Pal (2010, 19) explains that each

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[1] The pilot project is still ongoing, with no scheduled end date at this time. Evaluation of the program is also ongoing, and focuses on the level and nature of public interest in the program, the impact of the program on regional health authority staff workload, the financial impacts of the option for the regional health authority, and client satisfaction. Further research is required to investigate the complete evaluation plan and processes (V. Macey, Access to Information and Protection of Privacy Act Officer, Department of Health and Community Services, Newfoundland and Labrador, personal correspondence, March 8, 2017).

approach is based on a type of reasoning. For instance, legal assessments look at public policy through the prism of law, while logical analyses interrogate the inherent consistency and coherence of a policy (Pal 2010, 20). Normative policy analysis, on the other hand, evaluates a policy in reference to a set of basic moral values (Pal 2010, 20). Such analyses provide an important lens from which to understand social policies because not only do they help reveal the (often implicit) normative assumptions embedded in our social policies, but they also create space to consider critically these normative standards themselves. In other words, normative policy analysis encourages reflection and dialogue on the ethical dimensions of specific policies as well as the larger ethical frameworks and sets of values that inform our lives. Such dialogues are necessary if we are to deliberate on our policies *and* ethical frameworks so that both can be made to better reflect the values we want to shape our lives.

Given that the NPFCP shapes the material lives of its clients (as well as those of their caregivers), the ethics of care provides a unique ethical lens from which to evaluate the program. This lens, which is explicitly concerned with the messy moral value of our caring relations, provides a way to bring to the fore some of the ethical strengths and weaknesses related to this long-term care program. The goal of this paper, however, is not to provide a definitive evaluation of the program based on the 'criteria' of an ethics of care, as the ethics of care framework is not based on abstract principles or criteria. Rather, the goal here is simply to use the ethics of care as a lens to illuminate different aspects of the NPFCP, which can then be analyzed and assessed in conjunction with other policy criteria (i.e. economic and administrative concerns) in order to contribute to a larger dialogue on the potentialities and challenges of direct funding long-term care programs in the province of Newfoundland and Labrador.

A critical ethics of care

A critical ethics of care arises from the realities of caregiving and care receiving that shape and inform all of our lives, and therefore cannot be reduced to simple logic statements and generalized rules, wherein one person's moral actions in a particular situation can be universalized and extrapolated as moral across all situations. Thus, unlike many other ethics, the ethics of care cannot be neatly summarized as a list of abstract principles (Robinson, 1999, p. 40).[2] Instead, the ethics of care is based on certain tenets that provide a framework from which to conduct moral reasoning while recognizing that all situations and actions are unique, and that all ethical actions must consider such uniqueness. The ethics of care is therefore deeply concerned with context, and any moral guidelines stemming from the ethics of care must consider the specific and material particularities that shape and inform our lives.

The ethics of care also stems from a relational ontology, and the moral subject in the ethics of care is a 'relational self' (Hekman, 1995, p. 73). We are all (re)produced and sustained by our relations. While this statement tends to conjure images of personal relations, such as those between family and friends, it is important to understand that such relations constitute only one

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[2] At least, this paper does not use such principles. It is notable that there are care ethicists who rely on principles to some degree (cf. Collins, 2015).

part of the relational webs within which we are all entwined. Our individual identities, needs, and realities are shaped "through their intersection with a range of private and public social and institutional arrangements" (Hankivsky, 2004, p. 34). This includes our interpersonal interactions, but also the social, political, economic, and cultural systems that inform our lives. We are not individualized, atomistic, pleasure-seeking beings, but rather we are already-always connected to individual and personal relations, political, economic and social systems and structures, and landscapes of care in all their varied forms (Milligan & Wiles, 2010). In this way, the ethics of care serves as a lens from which to understand politics and power dynamics. The ethics of care prioritizes the relational reality that shapes all people's lives while acknowledging that care, politics, and ethics are intertwined (Tronto, 2013).

To further round out this understanding of a critical ethics of care, Tronto (1993) puts forward four moral qualities or elements of the ethics of care. These elements include attentiveness, which highlights the importance of recognizing needs (Tronto, 1993, p. 127); responsibility, which Tronto argues must be a flexible understanding of responsibility, rather than the stricter connotations implied by 'obligation' (p. 31); competence, which, as Tronto asserts, "align(s) this approach with moral consequentialism" (p. 133) in that competently providing/receiving care allows us to evaluate if the care relation is adequate (p. 133); and finally, responsiveness, which "signals an important moral problem within care: by its nature, care is concerned with conditions of vulnerability and inequality" (p. 134). This last element is meant to highlight not only the unequal power relations often involved in caregiving and care receiving, but also to indicate that the care receiver should have agency in this relation (p. 135).

While not all care ethicists use these elements (Hankivsky, 2004; Sevenhuijsen, 1998), this analysis draws upon Tronto's elements based on an understanding of the ethics of care as a microscope: it provides a critical lens from which to examine and understand the world around us, starting from the reality that care sustains and (re)produces us all. Like the knobs on a microscope, each of these criteria can be used to bring into focus different facets of the object of study. By using each criterion, and turning the knobs of the microscope, the ethics of care can uncover dimensions of the object of study that would otherwise remain hidden. Uncovering such dimensions is of the utmost importance when trying to investigate and assess moral dilemmas and issues. As Tronto also emphasizes, while each of these elements can be considered individually, the integrity of the ethics of care relies on the fact that these elements are intertwined and interacting in any care relationship (1993, p. 136); the microscope requires all of the knobs to function properly and reveal the underlying microbes.

Finally, it is important to note that, in many ways, the ethics of care's emphasis on context and relational specificities deviates from ethical framings that rely on universal standards of equality (Sevenhuijsen, 1998, p. 107). While it is beyond the scope of this article to articulate fully the arguments for an ethics of care approach versus frameworks premised on universal equality, Young's critique of equality in treatment (1989) – which, in a policy context, requires that social program delivery meet standards of equality – is particularly relevant to this paper. Young argues that equality in treatment is problematic because when differences exist among groups, "but some of these groups are privileged, strict adherence to a principle of equal treatment tends to perpetuate oppression or disadvantage" (1989, p. 251). That is, when everyone is treated the same, differences between groups cannot be addressed; this would violate the principle of equal treatment. While treating everyone alike may seem just, equal treatment does not necessarily lead to equal outcomes, particularly when pre-existing relations of oppression, domination, and exploitation are not specially addressed. The expectation that equality in treatment will lead to equality in results is thus potentially dangerous (Sevenhuijsen, 1998, p. 42), for "to assume equality among humans leaves out and ignores important dimensions of human existence" (Tronto, 1993, p. 135), specifically, the fact that we oscillate between various states of vulnerability and dependency throughout our lifetimes. This is of particular consequence to the elderly and aging population, who experience vulnerability in different ways, even within their group. According to the model of equal treatment, we cannot address pre-existing disadvantages, or the different needs and disadvantages that emerge through time, because to do so would be to violate the principle of treating all alike. However, in not providing such accommodations, we often create and perpetuate unjust circumstances, in which some people's needs are not fully addressed. For example, there is a problem with treating the elderly who participate in this program as a singular group whose needs are common to all within the group.

Care ethics, on the other hand, is concerned with relationships and responsibility, rather than standards of equality. This lens allows us to focus on how relations shape and meet our needs, and how responsibility for meeting needs is distributed. In this way, we can identify relations that negatively influence our ability to lead fulfilling lives, and we can address unfair distributions of responsibility for care. This approach is thus flexible. Unlike the idea of equality in treatment, which cannot explicitly address the different relations that inform the lives of the elderly clients of this program, care ethics can more readily accommodate people's unique positionalities, their intersectional experiences (Crenshaw, 1989), and provide a lens from which to assess the moral dilemmas which arise due to unique life experiences – such as those which characterize and shape the various caring needs of the elderly who require long-term care support. Thus, while the point of this piece is not to argue definitively for the rejection of equal treatment, the hope is that by using a different moral framework – based on the ethics of care – this analysis not only reveals tensions related to this specific program, but also implicitly allows us to reflect on the ethical standards which currently shape long-term care policies, and decide whether these standards are best suited for achieving our social policy goals.

The Newfoundland Paid Family Caregiver Program

The NPFCP is a direct funding program which allows eligible home support clients in the province to pay family members for some personal care and behavioural support services. Although this program targets both senior citizens and adults with disabilities, this paper focuses only on the senior citizen population.[3] The logic behind the program is to provide care receivers

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[3] The vast literature on disability and care often addresses issues that do not frequently arise in elder care - for instance, disability literature often highlights the oppressive history of care (Kröger, 2009; Williams, 2001) and thus the focus has been narrowed in this way for pragmatic reasons.

with increased choice in how their caring needs are met, specifically by providing a wage for family members to compensate and support their care work. As the Minister of Health and Community Services, Susan Sullivan,[4] wrote "Our design objective with the Paid Family Caregiving Option is to increase a client's flexibility and choice by making it easier for adults, who require and are assessed as eligible for home support, to hire a family member" (2013). The program is described as broadening the definition of family members who can provide care by including "parents, children, grandparents, grandchildren, siblings and [other] relatives [who are] residing in the same home" (Sullivan, 2013). The program excludes, however, spouses/common law partners from receiving financial compensation for their work on the grounds that "there is still the expectation that the natural[5] caregiving roles provided by these individuals will continue" (Sullivan, 2013).

This program retains the principles of the current home support system in Newfoundland and Labrador, but removes the barriers that prevent family members from being paid for caregiving (Government of Newfoundland, 2014b, p. 6). When an individual is interested in participating in this program, they are assigned a case manager who assesses the individual's eligibility. The eligibility requirements for participation in the NPFCP are outlined in the *Provincial Home Support Program Operational Standards* (Government of Newfoundland, 2005), and are based on: the need for care/behavioural support services, place of residence, and financial eligibility. Behavioural support is defined as "the provision of supervision to clients that have assessed behavioural support needs. It includes services to support clients where there is risk of harm to self or others and to support independence in the home and community" (Government of Newfoundland, 2014a). The individual must be 'a new client,' defined as "an individual who has not previously received service or an individual who has been with no service for a period of one year or more from the Adult Home Support Programs [which are publicly provided]" (Government of Newfoundland, 2014b, p. 14).

Once an individual is deemed eligible for the program, a 'plan of care' is developed based on an assessment of the individual's needs; this is done by the individual's case manager. While each plan will be unique to the individual, there are maximum thresholds for the eligible services. The total maximum monthly subsidy for seniors is $3325.00 (Government of Newfoundland, 2015), though the actual amount provided will vary based on the needs assessment. Funding is available for assessed personal care/behavioural supports to a maximum of four hours per day (Government of Newfoundland, 2015). Additionally, the client may be eligible for financial support for up to one hour per day for meal preparation and two hours per week for homemaking (Government of Newfoundland, 2015). Respite care funds are provided if the cost of the care provided by the family caregiver does not exceed the total monthly home

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[4] After the provincial election in November 2015, Susan Sullivan is no longer the Minister of Health and Community Services. However, her title is retained in this paper, as she was a central figure in the establishment of this program.

[5] While beyond the breadth of this paper to discuss, the assumption that certain people are 'natural' caregivers is, of course, very problematic.

support ceiling of $3325.00. Respite funding is only available to those clients who are assessed as requiring 24-hour care and supervision, and respite care cannot be provided by other family members (Government of Newfoundland, 2015). That is, under the NPFCP only one family care provider can be compensated for their care work.

Once a plan of care has been established, the client must register with the Canada Revenue Agency (CRA), administer a payroll to the caregiver, maintain employment records, and make the appropriate CRA remittances (Government of Newfoundland, 2015). The client (the care recipient) has the option of relying on a book keeper, or other such individual (any person except the paid family caregiver), to conduct these tasks on their behalf. This person (whether it is the client themselves or a third party) is known as the 'Funding Administrator' (Government of Newfoundland, 2015). The funding administrator receives the funding from the Government of Newfoundland and Labrador on a semi-monthly basis, and becomes the employer of the caregiver. The funding administrator is also required to keep a 'Record of Support Journal,' which is reviewed with the case manager on quarterly basis (Government of Newfoundland, 2015). Finally, if the Paid Family Caregiver option is chosen, it cannot be combined with any other Home Support Program service option (Government of Newfoundland, 2015). The participant can remove themself from the program, however, and then restart the assessment process if they would like to determine if they are eligible for other public care services.

Assessment

While the idea of paying for familial care work is a positive step, as this work has largely gone unnoticed and is socially undervalued, a critical ethics of care lens shows that a variety of tensions exist concerning how the program is shaping care work and how this may be affecting those who give and receive care. The ethics of care elements of contextual sensitivity and attentiveness, responsibility, competency, and responsiveness are useful starting points for critically exploring the wider implications of this program.

Contextual sensitivity and attentiveness

The NPFCP facilitates attentiveness in that the elderly in need of long-term care are provided with monetary resources that can be used to hire a family caregiver. That is, the program makes attentiveness possible by providing financial support for the care relation, in which the needs of the care receiver can be addressed. However, attentiveness also requires the careful consideration of the other person's unique reality – that is, the element of contextual sensitivity. The NPFCP does not include a platform or mechanisms to facilitate a thorough investigation of the context in which the need for long-term care arises. While each individual who wishes to be considered for this program is assigned a case manager, who will presumably pay attention to the unique circumstances that gave rise to the individual's needs, the ways in which the assessment of needs is conducted means that this type of contextual sensitivity is not possible, and only a partial picture of the individual's caring landscape can be captured. According to the *Provincial Home Support Program Operational Standards* (Government of

Newfoundland 2005), the three criteria used to assess an individual's eligibility for long-term care support are: need for service, place of residence, and financial eligibility. The need for service criterion uses an assessment instrument to determine functional need and to aid in the development of a service plan; the place of residence criteria is met if the individual lives in a 'self-contained residential unit,' such as a house, condominium, or apartment; and financial eligibility is evaluated based on the individual's liquid assets, income and living expenses (Government of Newfoundland, 2005: 8). Clearly, the evaluation of these criteria requires that a certain amount of attention be paid to the context in which the need arises. However, there are many facets that such a narrow assessment tool cannot possibly include. For instance, while the need is assessed, no attention is given to how that need arose in the first place. Information on structural issues that exacerbate caring needs may be missed without such analyses. This information could, if attentively assessed and analyzed, inform preventative policy, help us allocate resources to those who need it most, and most importantly, allow us to identify and work to rectify structural issues which negatively affect people's ability to live healthy and flourishing lives.

This program also does not necessarily consider whether caregivers will be attentive to the needs of the care receiver. There is no formal and consistent monitoring function, and the program offers no training or support to family caregivers.[6] According to one program document, there are currently no mechanisms to "objectively measure family capacity to care" (Government of Newfoundland, 2014b, p. 8), and as such, the program relies strictly on the caregivers' personal assessment of how much and what kind of care they can provide; while some individual caregivers may have the skills to provide attentive care, others may not.

Lastly, the needs of caregivers are completely ignored in this program – there is no support for caregivers, and no attention paid to their own caring needs. Thus, while it can be suggested that the NPFCP facilitates attentiveness in so far as it provides a monetary incentive to (re)produce a care relation between the family caregiver and the elderly care receiver, it does little to promote robust, on-going attentiveness. The latter requires continual work, entailing constant interrogation and (re)assessment of the caring landscape and the needs of all those in the care relation.

Responsibility

The NPFCP is also interesting from the standpoint of the question of responsibility. In the ethics of care, responsibility does not simply imply that someone (or some group) must take responsibility for care. Rather, responsibility is understood as already-always woven into our lives. The pertinent questions, therefore, are: how does the program impact the distribution of responsibilities, and how is this distribution affected by other factors?

The NPFCP undoubtedly affects the distribution of responsibilities for care in the province. Rather than providing professional or public caregiving services, this initiative

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[6] V. Macey, Access to Information and Protection of Privacy Act Officer, Department of Health and Community Services, Newfoundland and Labrador, personal correspondence, January 19, 2017.

(re)produces the distribution of caring responsibilities which sees care as a private concern between individuals or nuclear family units. While the government is taking financial responsibility for caregiving and receiving through this program, it also simultaneously allocates responsibility to both the family caregiver and the care receiver. The former must do the care work required to address the caring need, and the latter must become the employer of the caregiver and accept the responsibilities that come along with that designation. In this way, this program directly (re)enforces the idea that the family is, and should be, responsible for caregiving and care receiving; care is effectively (re)relegated to the home and (once again) characterized as a private concern.

To be clear, the main point of the analysis is not to judge this arrangement as inherently 'bad.' Indeed, many people prefer to have their caring needs met by their family members and other close personal relations. It is also important and morally valuable for care receivers to be able to determine who is involved in meeting their caring needs (Kelly, 2016); by monetizing the care relation, this program allows care receivers not only to choose their caregivers, but places the care receivers in a relative position of power. In the position of employer, care receivers can more actively shape and negotiate the particulars of the care relation. Furthermore, family members, particularly women, often already provide unpaid social reproductive and care labour (Grant et al., 2004; Waring, 1999; Williams, 2001). As the wages for housework literature has long pointed out, by paying these caregivers a wage, this program in many ways values and recognizes care labour as important, and may provide these caregivers with resources that can help them struggle against gendered norms which naturalize women as caregivers while simultaneously devaluing caring work (Federici, 2012, 15-27; 115-125). For some people, this arrangement could be quite liberating. Further, the point is not to claim that all care services should be provided publicly (i.e. through institutionalization). Indeed, as critical disability activists have demonstrated, state-centric caring arrangements have often been oppressive and paternalistic, and come with their own set of logistical issues (Kelly, 2016; Kröger, 2009; Williams, 2001). Instead, the salient point is that a critical ethics of care lens requires that we examine the ways in which responsibilities for care are distributed, and interrogate the assumptions underpinning these distributions. In this case, the program assumes family care taking as the norm. A critical ethics of care analysis, however, requires that we ask what the consequences are of this assumption. In the case of the NPFCP, one possible consequence is the downloading of responsibility for care back onto the family unit. If this program is the only probable or most desirable option available to elderly individuals in need of long-term care, families may feel added pressure to partake in the program, even when their own material and emotional realities do not allow for such additional responsibilities. Of course, this is not to say that obligations are, in and of themselves, necessarily negative. Instead, it is to point to the potential for 'overwhelming obligations,' in which our capacities to care-about (that is, to feel morally responsible for something or someone) outrun our capacities to care-for (that is, our capacity to provide the specific work needed to address the caring needs) (O'Dowd, 2016). As studies of caregiver fatigue illustrate (Day & Anderson, 2011; Lynch & Lobo, 2012), this could have very real consequences in terms of the provision of quality care, and in terms of the well-being of the caregivers, care receivers, and the family unit as a whole.

Second, the assumption that families are responsible for care further works to characterize care as a private concern. By bracketing care to the so-called private sphere, it obscures the fact that caregiving, care receiving, and care labour are deeply intertwined with politics and power. Consequently, this program is complicit in the gendered system which characterizes care as a 'woman's concern' and constructs the boundaries between the public/private sphere, thereby making it difficult to raise meaningful issues of care in the public discourse (Tronto, 1993; Tronto, 2013).

Competency

The criterion of competency once more reveals an important aspect of this program. From an ethics of care perspective, the consequence of the caring relation, and the degree to which the caring need is met, is morally important. The NPFCP, however, does not assess the ability of the family caregivers to provide effective, quality care, nor does it assess the context in which caring needs arise, therefore, ignoring any larger structural obstacles that may negatively impact the caring relation. Finally, the program does not provide training to the family caregivers. This is not to suggest that all of the family caregivers that participate in this program will provide incompetent care; nor is it to imply that they are not well-intentioned. Instead, it is to point out that while some caregivers are fully equipped to perform the care work and provide high quality care, others might not be. Unless there is a process in place to ensure that care is consistently and competently provided by caregivers, a critical ethics of care perspective suggests that this program is failing to ensure competent care.

It is also important to consider the issue of respite care in this regard. Under this program, the conditions under which respite care for the caregiver is provided are problematic. Funding for respite care is only available if the total monthly home support ceiling of $3325.00 is not exceeded, and if the case manager concludes that the care recipient is in need of care 24 hours a day, seven days a week. However, a contextually sensitive analysis of the care relation would not default to a generalized rule about how much care must take place before the caregiver deserves relief. Instead, a contextually sensitive analysis would take into consideration the caregivers' other responsibilities and the resources and support available to the caregiver. The dangers of applying a generalized respite 'rule' are immense when competency is considered. For example, while some people may be able to provide quality competent care for eight hours a day before they require relief, others may only be able to provide two hours of care. This is not to say that one individual is a naturally better caregiver than the other; rather, this is to acknowledge that we are located in different positions in different landscapes of care, with different access to power, resources, and privileges. All of these factors inform our caring relations; without a respite system in place to account for such factors, the provision of consistent, competent care, is in question.

Responsiveness

The element of responsiveness is meant to address the power relations inherent in all care relations – both the caregiver and care receiver must have space to respond to the care relation. The NPFCP does not have a concrete and systemic way to facilitate responsiveness, however.

While it could be argued that the care recipients, who are the formal ‘participants’ of the program, can voice concerns and provide feedback to their case managers, this does not ensure that responses will be heard at the appropriate level or taken seriously when the program as a whole is evaluated. Furthermore, family caregivers are not considered as participants in the program at all, despite the fact that the program has real implications for the ways in which they provide care, and indeed, affects the very structure of their lives. Instead, under the program, family caregivers are formally considered employees of the care recipients. Without a platform for both caregivers and care receivers to respond to the ways in which this program (re)organizes care, several questions arise: How will caregivers and care receivers voice their concerns about the program? Will caregivers and care receivers feel comfortable to express their concerns about the program given the complex care relations involved in the NPFCP?

This last question points to an important observation about the power dynamics involved in the caregiver-care receiver relation under this program. Relations of care, like all relations, involve power dynamics. The NPFCP involves at least two additional power dynamics, although in particular circumstances, an attentive, contextually sensitive assessment would likely reveal many more. For one, the care relation under this program is shaded by the power dynamics involved in family relations. Second, to further complicate such dynamics, the family relation takes on the additional characteristic of an employer-employee relation under the program, because the care recipient becomes the employer of the family caregiver. Employer-employee relations further involve complex power divisions. These power dynamics must be unpacked so that we can better understand how they inform the care relation. To do this properly requires attention to context and the provision of safe spaces for both parties to enable them to respond to the care relation. Neither of these elements are, in fact, built into the NPFCP, and therefore, from a care ethics perspective, this program fails to expedite responsiveness.

Targeted Care

In addition to downloading the responsibility for care onto the family unit, it is important to note that the provision of care under this program is not universal; rather, this program is a targeted social program. As Mkandawire explains, “Under universalism, the entire population is the beneficiary of social benefits as a basic right, while under targeting, eligibility to social benefits involves some kind of means-testing to determine the ‘truly deserving’” (2005, p. 1). The NPFCP is a targeted program as it involves the process of ‘means-testing’ which serves to determine who is eligible to participate in the program. The eligibility criteria for this program are: need, residential status, and financial status. The order in which these criteria are listed do not signify their order of importance or a weighting system; rather, all three of these criteria must be met in order to be eligible for this program. What is interesting about these criteria, however, is that two out of the three criteria are, in fact, indicators of ability to pay. Financial status is clearly an indicator of ‘ability to pay;’ it is an assessment of one’s ability to participate in the market based on one’s liquid assets, income, and expenses. Residential status is also an indicator of ability to pay – or at the very least, it is strongly related to ability to pay. Residential status indicates if you are a homeowner, if you can afford rent, if you live in a condominium. However, behind these basic labels lies the determining factor: can you afford to pay for these things?

Clearly, one's ability to pay is prominently factored into the determination of one's eligibility for this care program.

While there can be merit in targeting resources to those most in need, the fact that this is a targeted program and one heavily based on financial status, presents some issues. For one, as Mkandawire notes, "targeting itself almost by definition leads to segmentation and differentiation" (2005, p. 7). It involves the differentiation of 'the needy,' who require public assistance, from those who are well-off and thus 'independent' and (supposedly) able to access services through the market (Mkandawire, 2005, p. 7). This dual system, however, only serves to enhance class divisions and stigmatize participants further; the elderly care receivers in the program may come to be seen as 'drains' on public resources, given that they are deemed unable to 'care for themselves' financially. Furthermore, when eligibility to participate in the program is strongly linked to financial status, the program is not simply aimed at 'those in need;' rather, it is aimed at 'the needy poor.' Under this program, then, financial need appears to take priority over the actual caring need (which the program is apparently designed to address).

More concretely, targeting necessarily discriminates between those who are 'needy' and those who are not; this, however, runs the danger of committing either type I errors, whereby someone deserving of the service is denied access because they fail to meet the particular criteria used to determine eligibility, or type II errors, whereby an 'undeserving' person is able to access the program/service because, while they meet the eligibility requirements, the requirements may not provide the most effective way of discriminating between clients (Mkandawire, 2005, p. 9). Under the NPFCP, these errors are particularly likely to occur. The program is supposed to address a caring need. However, the eligibility criteria are heavily linked to financial status. It assumes that caring needs and low-income are necessarily correlated; what, then, of the people who may not be 'financially' needy, but who have unmet caring needs? This is an especially pertinent issue given the geography of Newfoundland and Labrador. The lack of both public and market-based care services in the rural areas means that, in some instances, financial resources are irrelevant to the question of having caring needs. For example, a person can be quite 'well-off,' but because there are literally no services in their area and because they have no family willing to care for them (whether for pay or for not), they may still face unmet caring needs.

Besides the stigmatization that often occurs when targeting is used to grant access to services, the use of financial status as a significant factor in determining eligibility is problematic from an ethics of care perspective for other reasons as well. If long-term care is to be publicly provided on a selective basis, the most important criteria in determining who 'deserves' access to this resource should be the unmet caring needs of particular individuals. Without this, the likelihood of type I and type II errors increases. Thus, while financial resources play a role in shaping the unmet caring needs, financial status, as an eligibility criteria, must be seen in relation to the support systems available to the individual, and be put in dialogue with the unique barriers faced by the individual within their particular landscapes of care. A critical ethics of care, which understands people as fundamentally relational beings and emphasizes the moral importance of caring relations, suggests that policies must examine the complexity of caring needs, as opposed to relying on simplistic evaluative criteria that are characteristic of targeted social programs.

Conclusion

This article has sought to demonstrate how a critical ethics of care lens provides a fruitful starting point from which to understand the ways the NPFCP (re)shapes care for the elderly in the province of Newfoundland and Labrador. The analysis finds that in defining clients based on one-dimensional statuses, the program fails to consider the wider contexts in which caring relations reside. A critical ethics of care lens further uncovers the ways in which the responsibility for care is being (re)distributed to the family through this program, thus reproducing the characterization of care as a private issue. This article has also explored the consequences of the targeted aspect of the program, and identifies many potential pockets of tension, particularly related to how the program (re)defines the caring relation as a family-employer-employee caring relation. Finally, and perhaps most importantly, this analysis raises the question of whether this program effectively attends to the needs it was meant to address – while family members may provide exceptional care, there are many inconsistencies in the program in terms of its ability to ensure that this occurs. The lack of assessment of the family caregivers raises the question of whether competent care will necessarily or consistently be provided. An ignorance of both the particular and wider context in which the caring needs of the elder individual arises, and narrowly defined notions of care and respite care, indicates that the production and maintenance of a healthy caring relation that meets the needs of both caregivers and care recipients may not be possible. While further research is required to understand exactly how the consequences of the design of the program manifest, this assessment uncovers several issues that must be carefully interrogated and examined as the pilot project moves forward.

Specifically, to understand better the ways in which the NPFC program (re)shapes caring relations, qualitative research is needed to explore the intersections of the roles of caregiver-care receiver/family/employee-employer that emerge under the program. Research is needed on the efficacy of the program in meeting the caring needs of the elderly clients, and on the consequences of the program for the care workers. It would also be useful to conduct research to compare this program with other home care programs. Finally, research into the evaluative plan for this program could provide fruitful insight into the normative standards used by the province to evaluate the success of the program. As this paper has argued, greater attention must be paid to the ways that this program facilitates attentive and competent care (or not), and the ways in which it allocates the responsibility for caregiving and care receiving; the evaluative criteria advanced by the ethics of care perspective would allow the province to focus on such concerns when evaluating the success of the current pilot project. In so doing, this could also serve to stimulate greater dialogue concerning the normative frameworks by which we assess social policies more generally.

References

Botting, I. (2001). Health restructuring and privatization from women's perspective in Newfoundland and Labrador. In *Exposing privatization*, ed. Pat Armstrong, Carol Amaratunga, Jocelyne Bernier, Karen Grant, Ann Pederson, and Kay Willson, 49-94. Aurora, ON: Garamond Press.

Collins, S. (2015). *The core of care ethics*. Basingstoke, UK: Palgrave Macmillan.

Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: A black feminist critique of antidiscrimination doctrine, feminist theory, and antiracist politics. *University of Chicago Legal Forum*, 57-80.

Day, J., & Anderson, R. (2011). Compassion fatigue: An application of the concept to informal caregivers of family members with dementia. *Nursing Research and Practice*, 1-10.

Federici, S. (2012). *Revolution at point zero: Housework, reproduction, and feminist struggle*. Oakland, CA: PM Press.

Government of Newfoundland. (2005). *Provincial home support program operational standards*. St. John's, NL: Department of Health and Community Services. Retrieved January 2, 2015 rom http://www.health.gov.nl.ca/health/publications/home_support_manual.pdf

Government of Newfoundland. (2012). *Close to home: A strategy for long-term care and community support services 2012*. St. John's, NL: Department of Health and Community Services. Retrieved February 26, 2014 from http://www.health.gov.nl.ca/health/long_term_care/ltc_plan.pdf

Government of Newfoundland. (2014a). Services in your region. Retrieved March 18, 2014 from http://www.health.gov.nl.ca/health/findhealthservices/in_your_community.html

Government of Newfoundland. (2014b). *Payment of family caregivers for home support services: Clinical staff*. St. John's, NL: Department of Health and Community Services.

Government of Newfoundland. (2015). *The paid family caregiving option*. St. John's, NL: Department of Health and Community Services. Access to Information Request filed by author, November 26, 2015. http://atipp-search.gov.nl.ca/public/atipp/requestdownload?id=967

Grant, K., Amarantunga, C., Armstrong, P., Boscoe, M., Pederson, A., & Willson, K. (Eds.). (2004). *Caring for/caring about: Women, home care, and unpaid caregiving*. Toronto: University of Toronto Press.

Hankivsky, O. (2004). *Social policy and the ethic of care*. Vancouver: University of British Columbia Press.

Hekman, S. (1995). *Moral voices, moral selves: Carol Gilligan and feminist moral theory*. University Park, PA: The Pennsylvania State University Press.

Kelly, C. (2016). *Disability politics and care: The challenge of direct funding*. Vancouver: University of British Columbia Press.

Kröger, T. (2009). Care research and disability studies: Nothing in common? *Critical Social Policy*, 29(3), 398-420.

Lynch, S., & Lobo, M. (2012). Compassion fatigue in family caregivers: A Wilsonian concept analysis. *Journal of Advanced Nursing*, 68(9), 2125-2134.

Mahon, R., & Robinson, F. (Eds.). (2011). *Feminist ethics and social policy: Towards a new global political economy of care.* Vancouver: UBC Press.

Milligan, C., & Wiles, J. (2010). Landscapes of care. *Progress in Human Geography,* 34(6), 736-754.

Mkandawire, T. (2005). Targeting and universalism in poverty reduction. Social Policy and Development Paper no. 23. Geneva: UNRISD.

O'Dowd, O. (2016). "Caring-about" and the problem of overwhelming obligations. *Hypatia,* 31(4), 795-809.

Pal, L. (2010). *Beyond policy analysis: Public issue management in turbulent times.* 4th ed. Toronto: Nelson Education Press.

Robinson, F. (1999). *Globalizing care: Ethics, feminist theory, and international relations.* Boulder, CO: Westview Press.

Sevenhuijsen, S. (1998). *Citizenship and the ethics of care: Feminist considerations on justice, morality, and politics.* London: Routledge.

Sevenhuijsen, S. (2003). The place of care: The relevance of the feminist ethic of care for social policy. *Feminist Theory,* 4(2), 179-197.

Sevenhuijsen, S., Bozalek, V., Gouws, A., & Minnaar-Mcdonald, M. (2006). South African Social Welfare Policy: An Analysis through the Ethic of Care. In *Socializing care*, ed. Maurice Hamington and Dorothy C. Miller, 69-87. Lanham, MD: Rowmand and Littlefield Publishers.

Sullivan, S. (2013). Paid family caregiving home support option will offer more choice to new home support clients. Retrieved February 24, 2014 from http://www.releases.gov.nl.ca/releases/2013/health/1209n02.htm

Tronto, J. (1993). *Moral boundaries: A political argument for an ethic of care.* New York: Routledge.

Tronto, J. (2013). *Caring democracy: Markets, equality, and justice.* New York: New York University Press.

Waring, M. (1999). *Counting for nothing: What men value and what women are worth.* Toronto: University of Toronto Press.

Williams, F. (2001). In and beyond new labour: Towards a new political ethics of care. *Critical Social Policy,* 21(4), 467-493.

Young, I. M. (1989). Polity and group difference: A critique of the ideal of universal citizenship. *Ethics,* 99(2), 250-274.