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Informal Caregiving: Current Trends in Public Policy and Service Provision

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The vast majority of long-term care assistance in this country is provided by family members through informal caregiving activities. This paper examines the mixed provision of initiatives available to assist informal caregivers of the elderly, including publicly subsidized direct services, indirect subsidies, and private welfare benefits. The implications of this mixed provision and financing of adult family care policies are discussed.

KEY WORDS: family care policy; caregiving; eldercare; adult care.

INTRODUCTION

The United States is currently experiencing a major demographic shift, with older Americans representing a larger proportion of the population (U.S. Bureau of the Census, 1993). Concomitant with the aging of the population is an increase in the number of persons experiencing several age-related disorders who may be in need of long-term functional and instrumental assistance. For example, growth in the number of persons with Alzheimer's and related-diseases, which are accompanied by a variety of cognitive (Reisberg, 1983), psychiatric, and behavioral impairments (Reifler, Larson, and Teri, 1986; Swearer, Drachman, O'Donnell, and Mitchell, 1988; Wragg and Jeste, 1989), has been reported (Evans *et al.*, 1989).

Long-term care services by definition include health, personal care, and social services delivered over a sustained period of time to persons who have limited capacity for self-care (Kane, 1987). In the United States, while formal services do exist, the vast majority of assistance is provided by family members through informal caregiving activities (Gatz, Bengtson, and Blum, 1991). For example, it is estimated that family caregivers provide approximately 80–90% of the instrumental assistance to the elderly (Brody, 1981).

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Among family members providing informal assistance to persons with health, cognitive, and psychiatric disorders, caregiving distress is a salient issue. For example, a caregiver's level of burden or distress has been found to be impacted by the predictability of the care recipient's problems (Pruchno and Resch, 1989) and the patient's physical, behavioral, and cognitive functioning levels (Deimling and Bass, 1986; Miller and Montgomery, 1987; Schulz, Tompkins, and Rau, 1988).

The purpose of this paper is to examine the current policy initiatives aimed at supporting family care of the elderly. This analysis will examine the mixed provision of initiatives available to assist caregivers, including publicly subsidized direct services, such as respite and adult day programs, indirect subsidies including tax credits and cash payment programs, and private welfare benefits such as corporate sponsored elder care programs. Implications of this mixed provision and financing of family care policies will be discussed, including the impact on elder autonomy, supply and quality of care, and the equitable access to services.

DIRECT SERVICE PROVISIONS

A mix of direct services exists, including respite care, in-home health and homemaker services, support groups, and adult day centers, which provide supplementary support for the familial care of the elderly. The accessibility of these services to care recipients and caregivers is contingent upon a number of factors, such as service availability, geographical location (urban or rural setting), the service needs and health limitations of care recipients, and the financial resources available to purchase assistance.

To date, the vast majority of federal long-term care expenditures are for institutionally-based services, and only approximately one quarter of the noninstitutional care of the elderly is publicly subsidized (Doty, 1986). For example, while Medicaid provides reimbursement for nursing home care for the impaired and impoverished elderly, it offers extremely limited reimbursement for community-based services (Able, 1987). Of the total 1980 Medicaid budget, only 1.4% covered home care services (Feldblum, 1985). Further, some public policies actually discourage home or family care of the elderly. For example, Social Security Supplemental Income (SSI) monthly payments are reduced by one-third if an elder lives with a family member (U.S. Select Committee on Aging, 1988).

Because public sector assistance for familial, informal caregiving has been limited, direct community-based services are primarily financed through such mechanisms as private transfers and partial public subsidies. In terms of public subsidies, there are a limited number of need-based programs that provide assistance for persons meeting specific eligibility requirements. For example, the Social Services Block Grant (formerly Title XX of the Social Security Act) provides low-income or Social Security Supplemental Income (SSI) recipients with home-based services, day services, and home-delivered or congregate meals (Kane and Kane, 1990). However, the 1981 Omnibus Budget Reconciliation Act (OBRA; U.S. PL 97-35), which originally eliminated Title XX of the Social Security Act replacing it with the Social Services Block Grant, reduced federal funding levels and eliminated state funding

matching requirements (Abel, 1987). OBRA, as implemented, provided for state Medicaid waivers for community-based services for the indigent elderly at extremely high risk of institutionalization. By 1986, 46 states had received Medicaid waivers for community-based services, although few programs are available on a statewide basis (U.S. Select Committee on Aging, 1988).

Title III of the Older Americans Act also provides partial funding for community-based services, targeting low income persons who are 60 and older for homemaker services, meals, and limited health services (Kane and Kane, 1990). However, funding levels are relatively low compared to other federally financed programs (U.S. Select Committee on Aging, 1988). Additional legislative initiatives have also provided increased but still relatively restrictive assistance for respite and other support services. For example, by 1985, 15 states had enacted legislation that provided limited funding for respite services for familial caregivers of the impaired elderly (Abel, 1987) and in 1986, the federal Respite Care Act provided for demonstration respite projects targeting Medicaid recipients (U.S. Select Committee on Aging, 1988). Also, legislation on both the federal and state levels has encouraged the development and implementation of caregiver support groups (U.S. Select Committee on Aging, 1988).

In response to fiscal constraints and cutbacks in social welfare spending, many publicly subsidized programs and/or entitlements are increasingly targeting low income, isolated elders without familial support who are at high risk of institutionalization (Branch and Stuart, 1984). Such a need-based approach penalizes, albeit inadvertently, those families providing care, and fewer services are available to assist care recipients who have familial caregivers actively involved in service provision.

As other cost containment measures have been implemented to trim federal expenditures on health and long-term care services, the demand for community-based services has increased and the problem of inadequate support services for familial caregivers has been further compounded. For example, Medicare's prospective payment system, which was implemented in 1983, had shortened the average hospital stay from 9.9 days in 1983 to 8.7 days by 1985 (Brown, 1988). Also, several states have begun utilizing Certificate of Need programs and instituted screening and preauthorization procedures to limit nursing home admissions and costs (Oriol, 1985). Although such policy initiatives may curb rising costs, they also further shift the burden of care of the impaired elderly to community-based or informal supports.

Considering the limited number of community-based services, homecare or homemaker services, both agency based and non-affiliated individual providers are increasingly in demand. Yet research has shown that more than 70% of the disabled elderly reside in areas where there are inadequate levels of home health care and homemaker services (Palley and Oktay, 1983). As noted, in comparison to institutionally based long-term care services, the public subsidization of homecare has been limited. Although the Medicare catastrophic legislation passed in 1988 would have provided payment for up to 80 hours of annual homecare for respite purposes, it was repealed in 1989 (Stone and Kemper, 1989).

Reimbursement issues and labor supply considerations further exacerbate the problem of limited homecare services. The majority of homecare workers are un-

trained, paid at minimum wage levels, and do not receive employment benefits (Oriol, 1985). Not surprisingly, such positions tend to experience high rates of turnover. For example, among home health aides the rates of turnover has often exceeded 60% annually (Holt, 1986).

While availability of direct services (homemaker, respite services) may be limited, they are the most preferred among caregivers (Horowitz and Shindleman, 1983; Sussman, 1979). Another advantage to direct public service provision is that, generally, the elder remains the primary recipient and service consumer, which in a sense supports the elder's autonomy. Public provision and/or financing also allows for the regulation and monitoring of the quality of care of such services. However, there are drawbacks. For example, publicly developed and maintained programs tend to reduce the flexibility and choice among consumers; there is an inadequate supply services; and publicly financed programs tend to be politically vulnerable and can be dismantled during politically conservative or economically recessive times.

INDIRECT SERVICE PROVISIONS

Several indirect service provisions such as tax allowances and cash payments for family members have been advanced to assist in the informal care of elders. With the political emphasis on privatization over the last decade, tax allowances that transfer funds directly to familial caregivers (consumers) are often a preferred form of family care assistance. There are currently three tax allowances—personal exemption, deduction, and tax credit—for which caregivers of the impaired elderly may be eligible (U.S. Select Committee on Aging, 1988).

In order for a taxpayer to claim a care recipient as a dependent, the following requirements must be satisfied: the dependent must live with or be related to the taxpayer and be a U.S. citizen; the dependent's taxable gross income for the year must be below $2,050; the dependent and taxpayer must not have filed a joint tax return; and the taxpayer must have provided more than half of the dependent's total support for the calendar year (U.S. Department of the Treasury, Internal Revenue Service, 1990). Although the taxpayer is allowed an exemption of $2,500 for each dependent, given the stringent level of these eligibility requirements the vast majority of caregivers are not eligible to claim such a federal tax deduction (U.S. Select Committee on Aging, 1988).

The Child and Dependent Care Tax Credit allows working taxpayers credit for expenses incurred due to caring for a mentally or physically disabled household member (U.S. Department of the Treasury, Internal Revenue Service, 1990). In order to be eligible for the tax credit, the care recipient must be incapable of self-care, not be the taxpayer's spouse or claimed as the taxpayer's dependent, and must co-reside with the taxpayer. In addition, the taxpayer must have paid for more than one half of the expenses of maintaining the joint place of residence, have earned income, and incurred all deductible care expenses due to meeting employment responsibilities. The maximum tax credit for the care of one disabled person is 30% of the maximum dollar limit ($2,400 for one qualifying care recipient and $4,800

for two or more persons) of allowable care expenses. In the event an employer provided dependent care benefits, the maximum allowable expenses must be reduced accordingly.

The Dependent Care Assistance Plan (DCAP), Section 125 of the Internal Revenue Tax Code, became effective in 1984 and allows eligible caregivers to set aside pre-tax dollars for medical or dependent care expenses (Denton, Love, and Slate, 1990). Participation in the DCAP program requires that the care recipient meet dependency criteria (Friedman, 1986). The taxpayer must be employed with a participating employer and the care recipient must reside with the taxpayer for a minimum of 48 hours per week (England, Levet, and Linsk, 1990). While the set aside monies are exempt from federal taxes and Social Security, if the funds are unused they are mandatorily forfeited by the employee. Such a model assumes predictable, stable care needs more congruent with the provision of childcare that with eldercare. Perhaps due to such program regulations, DCAP participation rates have been low. For example, among eligible employees, only approximately 7% participated in such a program in 1988 (Wyatt Company, 1989), and the vast majority of employees utilizing the DCAP program have done so to assist with childcare expenses, not costs associated with elder care (Friedman, 1986).

While in the past a dependent elder could be claimed twice as a personal exemption, the Tax Reform Act of 1986 circumscribed the application of tax incentives for the care of the impaired elderly. First, the Act eliminated elders' rights to claim themselves as personal exemptions if they are claimed as dependents on other tax returns (U.S. Select Committee on Aging, 1988). Also, the medical expense deduction for claiming the Child and Dependent Care Credit was raised from 5% to 7.5% of a taxpayer's adjusted gross income (U.S. Select Committee on Aging, 1988).

Increasingly, states are considering and implementing tax credits for the care of dependent family members. For example, Iowa, Idaho, Oregon, and Arizona have enacted tax provisions for the care of dependent older adults (U.S. Select Committee on Aging, 1988), although the states vary considerably in terms of allowance specifications and eligibility requirements. In a comparative study of Idaho's and Arizona's tax incentive programs, Hendrickson, Jewett, Emerson, and Seck (1988) found considerable variation in design and related outcomes of the two programs. Idaho's program was designed primarily to encourage caregiving assistance, particularly with an impaired elder's activities of daily living. Arizona's main objective, on the other hand, was to stimulate greater financial assistance of disabled elders by informal caregivers. Findings from this evaluative study indicate that both tax incentive programs seemed to encourage greater levels of care and involvement among informal caregivers.

Cash allowances, a form of compensation to families for their caregiving activities and/or to allow them to purchase services from nonfamily members, have been advanced as an indirect method of providing support for informal caregivers of the elderly. While cash payments are common throughout Europe for the care of dependent family members (Moroney, 1986), application of cash grants in the U.S. is far more restrictive and generally only provided to at-risk, low-income families. Linsk, Keigher, and Osterbusch (1988) found in a national survey that 70%

of the states permitted some form of payment for family caregivers. Such payments were, however, generally minimal and restricted to special circumstances in which the care recipients were at very high risk of institutionalization. Thus, as currently administered, few caregivers or care recipients are eligible for cash payment programs, with the exception of disabled veterans who are eligible for a subsidy from the Veterans' Administration Aid and Attendance program to compensate familial caregivers (Keigher and Murphy, 1992).

Among economic support options, caregivers report monthly support payments to be the most preferred type of governmental assistance (Horowitz and Shindleman, 1983). In a demonstration project on the impact of receiving subsidized monthly payments of approximately $2,000 per year, caregivers who received such compensation reported an increase in their ability to cope and to provide care, but such subsidies did not reduce the rates of institutionalization of the elderly care recipients (Whitfield and Krompholz, 1981). Keigher and Murphy (1992) found that cash payments to family caregivers were highly valued by both the informal care provider and the care recipient.

These indirect service provisions have both benefits and disadvantages. One of the primary benefits of both tax allowances and cash payments is the flexibility and choice they provide to consumers, in this case caregivers. Tax credits in particular have the advantage of providing uniform and administrative efficiency while not stigmatizing recipients (Eustis, Greenberg, and Patten, 1984). However, in both cases, given the stringent regulations and eligibility requirements, the vast majority of caregivers is not eligible.

Current application of tax credits also raises important equity issues. In general, the Dependent and Child Care Tax Credit has provided a disproportionate share of benefits to persons from upper income groups. While data on the use of the dependent care credit for the elderly is limited, in 1988 only one-quarter of the childcare tax credits went to families in the lower half of the income distribution (Robins, 1988). Since most impoverished families have limited tax liabilities and may not be able to afford the out-of-pocket care expenses for dependents, the application of tax credits may not be feasible (Kamerman, 1984). While more progressive refundable tax credits are being considered, the majority of current tax provisions has benefitted middle and upper income families while providing less assistance to poor or near poor families (Robins, 1988). In addition, only 1.5% of family caregivers cited a tax credit as their preferred method of obtaining governmental support for their caregiving activities (Horowitz and Shindleman, 1983).

Direct cash payments are generally need-based and provide assistance to low income families caring for an elder. However, most such programs are poorly funded, gap filling measures that differ significantly by jurisdiction. In general, such payments are only available in cases in which an elder is determined to be at high risk of institutionalization, and both the caregiver and care receiver are financially insolvent. As such programs have been applied, cash payments are most feasible for nonworking caregivers whose skills in the marketplace would be paid at or near minimum wage (Doty, 1986). Thus, such measures may inadvertently support long-term impoverishment of both the care recipient and care provider.

To date, impact of indirect service provisions, such as tax credits and cash payments, on the supply and quality of informal care for elders is unknown. Given the limited level of compensation, it is unlikely that these initiatives will increase the supply or availability of informal caregiving assistance. The cash allowance programs are also problematic in terms of their ability to provide for the purchase of services from nonfamily providers, since such an approach assumes the availability of services. Yet in the vast majority of locales there is an inadequate supply of support services or non-affiliated providers available through the private sector for caregiving or respite services.

Indirect subsidies also place the responsibility of obtaining, supervising, and evaluating informal care on the care recipient or family members (Doty, 1986). In both cases, service quality will likely be dependent upon the level of knowledge, information, and expertise of these service consumers. In terms of intergenerational implications, indirect subsidizes do provide limited support for familial caregiving. But since such provisions are paid directly to the familial caregivers, they may tend to support dependency rather than autonomy among care recipients.

PRIVATE EMPLOYMENT BENEFITS

Recently, funding and provision of services by the private sector to assist caregivers and their care recipients has received increased attention. Such private sector involvement has primarily taken the form of employer support for employed caregivers. For example, several experts suggest that elder care in the workplace will be one of the most important employment benefit issues in the 1990s (Kola and Dunkle, 1988). Several elder care programs are being marketed based upon the assumption that they will increase employee productivity and result in fiscal gains for business (Ingersoll-Dayton, Chapman, and Neal, 1990). Employment-based benefits have included educational seminars, employee support groups, resource and referral services, direct on-site adult daycare programs, respite services, flexible hours, and pre-tax dependent care allowances.

A few large corporate employers have begun instituting such services. For example, The Traveler's Life Insurance Company has developed an elder care program that provides a caregiver seminar, resource materials, flexible work hours, personal leave options, and a dependent care allowance, allowing employees to set-aside $5,000 per year for the care of an elderly family member at pre-tax level. Both Southwestern Bell and IBM have established elder care resource and referral services for employees, and Remington Products, Inc. has established a community-based respite program to serve its employees (Kola and Dunkle, 1988).

In one corporate setting with an existing elder care program, flexible hours were utilized by 82% of the employed caregiving respondents, family illness hours by 74%, lunch time seminars by 39%, and employee assistance programs by 36% (Scharlach and Boyd, 1989). Flexible work schedules and family leave are the benefits employed caregivers have indicated to be of greatest assistance (Fredriksen, 1993; Scharlach and Fredriksen, 1994). In another study by Anastas, Gibeau, and Larson (1987), employees indicated that their highest service priority was elder care

information (70%) followed by flextime, fewer working hours, a cafeteria benefit structure, day centers, respite care, and job sharing opportunities. Yet to date, according to a survey of American businesses, only 5% of employees are covered by a flexible benefit or cafeteria plan (U.S. House of Representatives, 1989).

Until recently, the United States remained the only industrialized country in the world without a national parental or family leave policy (Cranston, 1990), and it is estimated that U.S. female workers absorb an approximate loss of $5 million in annual earnings given the absence of compensated family leave legislation (Older Women's League, 1989). On the federal level, family leave legislation was first introduced in 1984 but did not initially incorporate an adult care provision. In 1989, The Parental and Medical Leave Bill (House Bill 770) was passed by both the House and Senate, requiring businesses with at least 50 employees to allow 12 weeks a year for unpaid medical or dependent care leave. The bill, as originally written, mandated the continuation of health care benefits during the leave period, insured returning employees the same or equivalent positions, and defined dependent care to include adult family members.

In June 1989, the bill, which would cover approximately 1,675,000 workers at a cost of $188 million dollars annually (U.S. House of Representatives, 1989), was vetoed by President Bush on the grounds that it placed undue burdens on business and did not support the voluntary benefits worked out through employee and employer negotiations. The bill, however, was reintroduced and passed during a more recent Congressional session, and signed into law by President Clinton on February 5, 1993.

At a time when there has been economic retrenchment from public social welfare spending, the involvement of the private corporate sector in providing elder care benefits seems promising. By shifting the responsibility to the private sector, public funds can be targeted for services or needs for which there are no other available funding sources. Also, given that informal care providers are a hard-to-reach population, providing assistance at the work site may provide a unique and effective means to access employed caregivers.

There are, however, a number of important considerations. Having elder care benefits available through the corporate sector may create a tiered system of benefits, with one service system for those employed in the corporate sector and another for those dependent upon public subsidies or programs. Linking elder care benefits to employment also raises other serious equity and access issues. For example, the provision of services would likely be dependent upon such factors as the types and sizes of businesses, the unionization of particular industries, and the overall health of local economies.

In general, access to employee benefits relates to such factors as seniority and occupational status, with those in higher positions getting a disproportionate share of benefits and wages (Wilensky, 1975). Thus, by concentrating elder care assistance in the corporate sector, those most likely to access such services are those who are most able to afford purchasing such assistance privately. For example, while familial caregivers are primarily women, the majority of women workers are concentrated in low paying positions (U.S. Department of Labor, 1986), and persons with the lowest incomes are at the highest risk of having to terminate employment in order

to meet their caregiving responsibilities (Brody, 1981). Given that more women, racial, and ethnic minorities, and persons from lower socioeconomic classes are unemployed or working in part-time, low paying positions with lower status, they are the least likely to be served by such initiatives.

In general, businesses tend to evaluate the feasibility of a benefit according to an assessment of its ease, cost and risk of implementation (Denton *et al.*, 1990). Although gerontologists and policy specialists are increasingly looking to the private sector to provide service and support provisions to employed caregivers, such expectations may be somewhat premature. For example, in a survey of U.S. businesses, only 7% of the respondents indicated that they were considering the development of services to assist their employed caregivers (Kola and Dunkle, 1988). In a study by the University of Bridgeport, it was found that three out of 105 surveyed businesses had elder care services (Creedon, 1988).

In the Kola and Dunkle (1988) survey, more than one-half of the businesses did not see caregiving of the elderly as a presenting problem for their company. Forty percent felt that employers should assist employees with problems related to the care of a family member, but only 17% indicated this in reference to providing care for an elderly family member (Kola and Dunkle, 1988). In a survey conducted by Fortune Magazine (1989), 67% of the responding companies reported providing personal days, unpaid leaves (61%), paid leave (17%), and flextime (10%) for the care of impaired elderly dependents.

While businesses seem to recognize the needs of employees to care for dependent children more than dependent elders, comprehensive childcare has, historically, been a difficult employment benefit to obtain. The corporate sector's provision of childcare would seem illustrative of their level of future involvement in providing elder care services. There are a number of federal and state private sector tax incentives to encourage employment-based and subsidized childcare, yet such benefit expansion has been limited. For example, of the six million U.S. employers, only an estimated 2,500 offer any kind of childcare benefit (Friedman, 1985). Even among the limited number of employers who provide some type of childcare assistance, over one-half provide the least expensive and most minimal of benefits possible (Friedman, 1986). When examining only medium to large firms, only approximately 1% of the employed in the U.S. receive partial assistance with childcare costs (U.S. House of Representatives, 1987). In terms of the Dependent Care Assistance Program which allows pre-tax dollars to be set aside for dependent care, it has been estimated that only approximately 1,000 U.S. employers offer such a benefit as part of a flexible benefit structure (Friedman, 1986).

Family leave policy, a legislative mandate in the private sector, is an important step in providing flexibility and assistance for employed caregivers. While such legislation has not been a priority aging-related issue, the benefit, as proposed, is intergenerational by design and provides a unique opportunity for coalition building among the senior lobby and childcare advocates (Wisendale, 1988). But as a direct employment-based benefit, it is limited by many of the same drawbacks as the corporate sponsored elder care services. For example, since it is contingent upon steady, full-time employment in a rather large business (more than 50 persons), it is evident that a number of caregivers will not be covered by its provisions. More

than 85% of U.S. employers have 20 or fewer employees (U.S. Bureau of the Census, 1984). And since the vast majority of family leave statutes are written to provide uncompensated leave, the employees, by design, require adequate resources in order to utilize such a benefit.

CONCLUSION

Although familial caregiving is the primary mode of long-term care assistance in this country (Gatz *et al.*, 1991), as this examination has demonstrated, there are only limited support services or policy initiatives available to assist caregivers and care recipients. To date, the current mix of policy and direct service initiatives raise questions regarding the provision and access to elder care services, and there exists a fragmented array of service options incorporating corporate based elder care programs, indirect public subsidies, and direct service programs.

This fragmented approach is indicative of several basic value dilemmas inherent in American society. The debate centers around such issues as the appropriate role of the state, local community, business, and family in providing assistance for elders. Further, it highlights a tension between publicly provided service provision vs. market economy service development, and it questions the appropriate level of federal, state, or local governmental involvement in assisting elders, families, and the employed. All of these issues reflect a basic ambivalence regarding private vs. public responsibility in providing assistance to families and the elderly in this society.

Caregiving services are, in general, labor intensive and do not lend themselves to being a highly profitable endeavor. Thus, overall involvement of the private sector in stimulating the expansion of such services may be limited, and a public role will likely be necessary. The public provision and/or subsidization of such services can also allow for increased uniformity of service delivery, and provide for the regulation and monitoring of services. But, given the costs of comprehensive services, the public subsidization of community-based assistance will not be an inexpensive solution to the rising costs of institutionally based long-term services. Such community-based services can, however, offer an important means by which to assist caregivers and care recipients, and society at large, by maintaining impaired elders in the community.

Existing tax incentives need to be reviewed and restructured as necessary, to insure nonregressive and refundable tax incentive benefits that provide equitable access for caregivers of all economic strata. Also, future tax incentives must be carefully devised to provide benefits that meet the needs of caregivers of the elderly as well as those of younger family members. In the design of future family care legislation, it will be imperative to insure that age-based biases are not inadvertently interwoven into such initiatives.

Although corporate sponsored initiatives raise serious accessibility issues, the private sector does have an important, viable role in providing assistance for employed caregivers. Businesses are uniquely positioned to act as a focal point for information and referral, and to sponsor support and educational services such as caregiver support groups. Considering that caregivers are a hard-to-reach popula-

tion, providing information and limited support services at the workplace creates a unique opportunity to access caregivers.

Further development of initiatives and opportunities that promote job flexibility will also benefit employed caregivers. Family leave, flextime, compressed work schedules, job sharing, and increased part-time job opportunities will be important developments in making the workplace more amenable to caregivers. The feasibility of additional innovative benefits needs to be continually explored. For example, portable pensions have been developed that allow for pension transfers with job changes or career interruptions (Denton *et al.*, 1990). As such directives are advanced, a rigorous and continued analysis of who is and who is not served by such initiatives will be essential.

Although most past discussions of family care have focused on issues most relevant to children and their families, the debate has recently expanded to encompass the needs of impaired elders. Such an intergenerational framework has the potential to broaden and redefine the relevant issues according to care needs rather than relying on an arbitrary and restrictive age based approach. This perspective highlights the need for family care of dependents across all generations, and is paramount for developing an equitable and responsive public policy agenda.

In order to begin assessing the impact of policy initiatives on familial care of the elderly, several issues warrant further exploration. For example, what is the short term and long range fiscal impact of providing or not providing various service initiatives? What types of direct and indirect service provisions and financing mechanisms most benefit caregivers and care recipients? How do the needs and experiences of these two groups differ? What are the societal implications of the various service and financing options and how are they impacted by gender, race, and socioeconomic status? What type of public policy initiative and support services are responsive to the continuum and diversity of care needs across generations. It is paramount that we, as a society, address these issues and begin to define the appropriate public and private role in providing assistance with familial caregiving. Given the limited accessibility and fragmentation of the existing mix of services, a more unified and comprehensive approach to family care is necessary.

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