



Special Senate Committee on Aging Final Report

Canada's Aging Population: Seizing the Opportunity

The Honourable Sharon Carstairs, P.C., Chair The Honourable Wilbert Joseph Keon, Deputy Chair

April 2009

This report is dedicated to the seniors who have not had the support they need as our society has tried to come to terms with monumental societal shifts which have inadvertently shunted them to the sidelines.

It is dedicated to seniors who have held onto the hope of a better world in which to age.

It is dedicated to the seniors, advocates, caregivers, health care workers, academics and other experts who have devoted their lives and energies to bringing about this better world, who have so generously shared their passion with this Committee.

For more information, please contact us by e-mail: age@sen.parl.gc.ca by phone: (613) 990-0088 toll free: 1 800 267-7362 by mail: The Special Senate Committee on Aging The Senate, Ottawa, Ontario, Canada, K1A 0A4 This report can be downloaded at: www.senate-senat.ca/age.asp

Ce rapport est également offert en français

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Membership

The Honourable Sharon Carstairs, P.C., Chair The Honourable Wilbert Joseph Keon, Deputy Chair

And

The Honourable Senators:

Maria Chaput Anne C. Cools Jane Cordy Terry M. Mercer Terry Stratton

Ex-officio members of the Committee:

The Honourable James Cowan, (or Claudette Tardif) and Marjory LeBreton, P.C., (or Gérald Comeau)

Analysts from the Parliamentary Information and Research Service of the Library of Parliament:

Julie Cool Havi Echenberg Nancy Miller Chenier Michael Toye Karin Phillips

Senate Committees Directorate: Keli Hogan, Clerk of the Committee Monique Régimbald, Administrative Assistant

Research Staff:
Michelle MacDonald, Special Advisor to the Committee

Order of Reference

Extract from the *Journals of the Senate* of Tuesday, February 10, 2009:

Resuming debate on the motion of the Honourable Senator Carstairs, P.C., seconded by the Honourable Senator Hubley:

That a Special Committee of the Senate be appointed to examine and report upon the implications of an aging society in Canada;

That, notwithstanding rule 85(1)(b), the committee be comprised of seven members, namely the Honourable Senators Carstairs, P.C., Chaput, Cools, Cordy, Keon, Mercer, and Stratton, and that three members constitute a quorum;

That the committee examine the issue of aging in our society in relation to, but not limited to:

- promoting active living and well being;
- housing and transportation needs;
- financial security and retirement;
- abuse and neglect;
- health promotion and prevention; and
- health care needs, including chronic diseases, medication use, mental health, palliative care, home care and caregiving;

That the committee review public programs and services for seniors, the gaps that exist in meeting the needs of seniors, and the implications for future service delivery as the population ages;

That the committee review strategies on aging implemented in other countries;

That the committee review Canada's role and obligations in light of the 2002 Madrid International Plan of Action on Ageing;

That the committee consider the appropriate role of the federal government in helping Canadians age well;

That the committee have power to send for persons, papers and records; to examine witnesses; to report from time to time and to print such papers and evidence from day to day as may be ordered by the committee;

That the committee be authorized to permit coverage by electronic media of its public proceedings with the least possible disruption of its hearings;

That, pursuant to rule 95(3)(a), the committee be authorized to meet during periods that the Senate stands adjourned for a period exceeding one week;

That the papers and evidence received and taken and work accomplished by the committee on this subject during the First and Second Session of the Thirty-ninth Parliament be referred to the committee; and

That the committee submit its final report no later than April 30, 2009, and that the committee retain all powers necessary to publicize its findings until 90 days after the tabling of the final report.

The question being put on the motion, it was adopted.

Paul C. Bélisle

Clerk of the Senate

A Message from the Chair

This Committee was originally struck by the Senate in the Fall of 2006. In the intervening two and a half years there have been two prorogations and an election. Each time the Committee has had to be re-struck and given a new order of reference by the Senate.

The Committee worked long hours over many months, requiring the services of a large number of procedural, research and administrative officers, editors, reporters, interpreters, translators, messengers, publications, broadcasting, printing, technical and logistical staff who ensured the progress of the work and reports of the Committee. I wish to extend my appreciation, and the appreciation of my colleagues on the Committee, for their efficiency and hard work.

In particular, I would like to acknowledge the contributions of Julie Cool, Analyst from the Parliamentary Information and Research Service, who has been the key researcher throughout each stage of the Committee's work.

The Committee also benefited from the assistance of two very capable Committee Clerks during the life of the study, François Michaud and Keli Hogan. Along with the administrative assistant to the Clerk of the Committee, Monique Régimbald, they were responsible for organizing all the meetings the Committee, including scheduling the appearances of all the witnesses, for overseeing the translation and printing of all the reports, and for responding to requests for information about the Committee's work and for copies of the Committee's reports.

I would also like to thank Michelle MacDonald, Special Advisor to the Committee, for her valuable assistance throughout the Committee's study.

Karen Schwinghamer, Senate Communications Senior Advisor, also provided valuable assistance throughout the study in helping to publicize the work of the Committee.

But most of all, I would like to acknowledge the dedication and passion of Canadians working with the aged who shared their stories with the Committee. As we work to implement a new vision for embracing the challenge of an aging population in Canada, we must learn from their experiences, build upon our successes, challenge ourselves to embrace new ways of thinking, and seize for opportunities for multi-jurisdictional collaboration to build a better, more inclusive Canada for the future.

The Honourable Sharon Carstairs, P.C. *Chair*

Foreword

In November 2006, the Special Senate Committee on Aging was created with a broad mandate to review a wide range of complex issues to determine if Canada is providing the right programs and services at the right time to the individuals who need them.

The Committee has reviewed public programs and services for seniors, identified the gaps that exist in meeting their needs, and examined the implications for service delivery in the future as the population ages.

The Committee released an interim report in February 2007, *Embracing the Challenge of Aging*, which summarized the findings of the first phase of the study. That report identified overarching questions, organised into four broad themes: defining seniors; the diversity of seniors and their needs; promising policy approaches; and the role of the federal government.

Using these four broad themes to frame its work, the Committee undertook to examine these issues in more detail in the second phase of its study. This included a series of hearings and a questionnaire sent to seniors' organizations across Canada to elicit their views on issues important to them.

In March 2008, the Committee released a second interim report, *Issues and Options for an Aging Population*. In its second report, the Committee identified key public policy issues with respect to the aging of the population and presented a set of potential options for addressing these issues.

Since March 2008, the Committee was engaged in the third and final phase of its study where it invited expert witnesses to testify at roundtable hearings and travelled throughout Canada to hear from Canadians on the issues and options presented in the second interim report.

The Committee visited Halifax, Nova Scotia, Moncton, New Brunswick, Sherbrooke, Quebec, Welland, Ontario, Ste. Anne, Manitoba, the Sagkeeng First Nation in Manitoba, Vancouver, British

Columbia and Victoria, British Columbia. The Committee went out and met where seniors gather in order to hear their personal stories.

In this final report of the Special Senate Committee on Aging, we set out a comprehensive vision for government, organizations and individuals to embrace the challenges of an aging population.

This report contains recommendations in the broadest sense of the term. The Committee is a creature of the Senate, and as a consequence, it is rooted in the federal level of government. The Senate can only, in the strictest sense, make formal recommendations to the Senate.

At the same time, the Committee wants to share the wisdom it heard from our many witnesses. As a result, this report contains recommendations that represent a consensus reached by members of the Committee to endorse a course of action or an idea that emerged in our deliberations.

Even though many of these concern other levels of government, or the private and volunteer sectors, the Committee felt that it was worthwhile including the recommendations in the hope that they would inform, engage and inspire action at every level and in every aspect of our society.

A Few Words About Definitions

The Canadian population is aging. It is a demographic trend that can be neatly plotted in graphics, counted in statistics. We are living longer.

Statistics Canada recently put numbers to this fact, pointing out the number of people aged 100 or older increased 50 percent between 1996 and 2006, and is set to triple to more than 14 000 by 2031. This made national headlines.

Meanwhile, Canadians are having fewer babies, shifting the historical balance between the young and the old. Add to that the reality that the baby-boom generation is entering the retirement years, and it becomes unavoidable and clear – the Canadian population is aging.

If we understand growing older to be a proxy for retreat from paid work, for physical decline and inactivity, and for increased dependence, then we have the makings of a crisis on our hands. But the generations that are now in the oldest age groups have charted a new meaning of growing older. They have begun to retire the stereotypes of aging, setting out new and exciting ways of aging.

It is widely believed that the baby-boom generation is likely to push the reality of aging to new limits, completely redefining the concept. This poses a challenge to the crafting of a report such as this – what exactly do we mean by aging and seniors?

Throughout this report, the terms "seniors" and "older Canadians" are used interchangeably. Some commentators have identified categories of "young old", "middle old" and "frail old" - some have gone further and associated specific age brackets with each of these categories.

In our first interim report, this Committee grappled with the definition of seniors, asking whether age should define eligibility for access to programs, and whether the current definition of seniors as those over the age of 65 still serves seniors, employers, and the rest of society.

In the end, we leave it to the reader to define what they mean by seniors. There are as many ways to age as there are individuals aging. Some 60-year-olds may associate strongly with the term seniors. They many have a positive view of being a senior or elder. The term may be imbued with a sense of the wisdom which one acquires through life experience, or with well-deserved retirement from paid work.

Others may react strongly against the label "senior" and the meaning which is currently ascribed to it.

So we will use the terms "seniors" and "older persons" loosely and give full licence to the reader to determine whether or not these categories apply to them.

As we will see in the next chapter, the ever-present risk we are trying to avoid is falling into the trap of ageism, where individuals are defined by their age alone. So where it is more appropriate, we will define more clearly the groups to which we are referring, such as

"persons eligible for retirement," "retired persons" or "residents of long-term care facilities."

Much attention is given in this report to the needs of those who are often described as the "frail elderly". This is not because the committee perceives this to be the norm for aging, but rather because we have been compelled by the testimony we have heard to raise certain alarms about issues specific to this group.

And here again, we note the inherent risk in the use of the term "frail elderly", as it suggests that there is a group of people which is predominantly defined by their frailty.

We strongly reaffirm that the frailest among us are much more than the sum total of their incapacities; that they contribute to society, not only in their past achievements, but in the dignity of who they are today.

It is simply our hope that the term "frail elderly" might allow us to find a common language so that seniors, caregivers, practitioners, policy-makers and politicians might boldly set out to bring about changes which fully recognize the human dignity in the options we set forth for the oldest among us.

Setting the Vision

The Committee was tasked with a broad mandate to review public programs and services for seniors, identify the gaps that exist in meeting the needs of our aging population, and make recommendations for service delivery in the future.

The challenge of an aging population goes far beyond the responsibilities of the federal level of government as defined in the Constitution. It must be a concern for every Canadian, for every province, territory and municipality, for every business large and small, for every volunteer organization and NGO.

The federal government has a strong role to play in meeting the challenges of an aging population. In the Committee's view, the federal government has three main roles:

- To provide leadership and coordination for multijurisdictional approaches to addressing the needs of our aging population;
- To provide support for research, education and the dissemination of knowledge and best practices; and
- To provide direct services to certain population groups for which it has a direct responsibility.

But, meeting the challenge of an aging population will require engagement and cooperation at every level and in every quarter.

What the Committee Learned

We celebrate statistics demonstrating that each generation lives longer than the last. Much attention has been paid to adding years to life. The exponential growth of the oldest age groups makes front page news.

But the Special Senate Committee on Aging found another story as we travelled across the country speaking to seniors. We heard a call to recognize the place of seniors as active, engaged citizens in our society; a call to afford older Canadians the right to choose to age in the place of their choice; a call to place as much importance on adding life to years, as we do on adding years to life.

Above all, we heard a call to recognize the aging population as an opportunity for Canada.

The Committee celebrates the aging of our population as a success story, but has identified gaps in services and programs which need to be addressed.

The Committee learned...

Seniors are often unjustly stripped of their rights.

Seizing the opportunity of an aging population will, first of all, require that we become aware of our own stereotypes relating to aging, and of the barriers which these stereotypes have created in the life of seniors.

There is no place for ageism in a progressive country like Canada. People are capable of much more than they think they are.

Today's seniors run marathons, overcome lifelong challenges, and volunteer countless hours. Stereotypes die hard, however, and too many seniors are limited by "self-adopted ageism" and by overt forms of ageism.

Ageism is pervasive and subtle. Turning the tide of opinion in a youth-oriented society, in such a way that the full rights of seniors are respected, will require an aggressive public relations campaign.

It will require a concerted effort to ensure that the strictest possible standards are adhered to before making competency determinations which can strip seniors of their dignity by denying them the right to make the most intimate decisions about their lives.

The Committee learned...

Illogical care decisions are made because we don't provide the right services at the right time.

Seizing the opportunity of an aging population will mean enabling a shifting of resources from the acute care health system to

an integrated continuum of care which will allow people to age in the place of their choice with the right services at the right time.

The Committee learned...

The unequal rate of the aging of the population across the country creates challenges for provinces to provide a comparable range of services.

Seizing the opportunity of an aging population will mean taking steps to make sure that comparable health and social services are available across the country, and that governments and service providers in regions which are aging more rapidly have the financial capacity to provide adequate choices.

The Committee learned...

Some seniors live in isolation or in inappropriate homes because of inadequate housing and transportation.

Seizing the opportunity of an aging population will mean creating spaces that accommodate active aging in age-friendly cities and rural and northern areas so that our communities can meet the needs of people of all ages and ensure that structural barriers to aging in place are systematically identified and removed.

The Committee learned...

Current income security measures for our poorest seniors are not meeting their basic needs.

Seizing the opportunity of an aging population will require us to recognize that different groups have different access to income and wealth in their senior years, and to acknowledge the fact that the basic income levels provided by the Old Age Security and the Guaranteed Income Supplement do not even meet the poverty line¹. No one in Canada should be allowed to age in poverty.

Statistics Canada does not have an official poverty line, however many organizations in Canada use Statistics Canada's low income cut-offs (LICOs) as a proxy for poverty. The LICOs identify Canadians who pay a disproportionate share of their income on the necessities of housing, food and clothing. This report uses the terms low income cut-offs and poverty line interchangeably.

The Committee learned...

The current supports for caregivers are insufficient, and Canadians are forced to choose between keeping their jobs and caring for the ones they love.

Seizing the opportunity of an aging population will force us to acknowledge the value of providing care to families and friends. Like other Canadians, seniors find themselves on both the providing and receiving ends of care. We all stand to benefit from the range of supports which allow people to care for those they love.

The Committee learned...

The voluntary sector, a critical component in supporting an aging population, is suffering as volunteers themselves are aging.

Seizing the opportunity of an aging population will require us to acknowledge the key role played by the voluntary sector. With adequate preparation, the voluntary sector will be able to benefit from the accumulated knowledge and experience of retiring seniors to strengthen our social fabric. At the same time, some seniors also rely on volunteers to help provide them with the programs and services they require. A strong voluntary sector is critical to meeting the needs of our aging population.

The Committee learned...

Canada is facing challenges in health and social human resources as doctors, nurses and social workers are themselves aging.

Seizing the opportunity of an aging population requires that we address the human resource challenges in the health and social sectors. Canada needs an informed work force which can identify healthy aging and put high quality services in place when required. This requires education and training.

The Committee learned...

Technology is providing new opportunities to deliver care.

Seizing the opportunity of an aging population at a time when technological advances are so well developed will require innovative approaches which will allow people to use technology to age in the place of their choice. Technology can be used to bridge the distance between specialists, who frequently practice in cities, and those in rural and remote communities. It can allow those with chronic conditions to be easily monitored in the comfort of their own homes.

The Committee learned...

The Canadian government is both a leader and a laggard in providing care to seniors under its jurisdictional responsibility.

The opportunities of an aging population must be seized for all Canadians, including those for whom the federal government has a direct responsibility. The federal government must lead the way, both as an employer and in the role it plays meeting the needs of veterans, and those in correctional institutions. Equally important is the fiduciary responsibility of the federal government towards First Nations and Inuit communities. Federal resources for First Nations and Inuit communities must at a minimum provide a level of care comparable to other communities.

Implementing the Committee's Vision

The aging population will change the way we do things. We can allow this change to happen by passively reacting to change. Or we can anticipate it and meet the challenge by design.

We believe that in order to realize a society free of ageism, where seniors can access appropriate supports and services when they need them, where no senior is living in poverty, and adequate supports are in place for people to age in their place of choice, governments at all levels will need to work in cooperation with the private and voluntary sector to initiate change.

We feel strongly that there are certain overarching recommendations which are essential underpinnings of our plan to seize the opportunity of an aging population to build a better, more inclusive Canada. These recommendations provide a framework for the Committee's vision.

We recommend that the federal government:

- Move immediately to take steps to promote active aging and healthy aging and to combat ageism;
- Provide leadership and coordination through initiatives such as a National Integrated Care Initiative, a National Caregiver Strategy, a National Pharmacare Program, and a federal transfer to address the needs of provinces with the highest proportion of the aging population;
- Ensure the financial security of Canadians by addressing the needs of older workers, pension reform and income security reform;
- Facilitate the desire of Canadians to age in their place of choice with adequate housing, transportation, and integrated health and social care services; and
- Act immediately to implement changes for those populations groups for which it has a specific direct service responsibility, and in relation to Canada's official language commitments.

Other recommendations found throughout this report expand upon and provide some specific means of implementing these primary framework recommendations. A complete list of recommendations can be found on page 203.

Chapter 1: Countering Ageism

If this Committee had initiated a study on all Canadians of all ages, what would we have concluded? That some are wealthy, while others live on the margins. That some have been here for many generations, while others are settling into our country. We probably could have concluded that most teen-agers lead very different lives from the average 30-year-old, though they are relatively close in age. It would probably have been impossible to write a report which fully encapsulated all of their realities.

The Special Senate Committee on Aging was struck in November 2006 with a mandate "to examine and report upon the implications of an aging society in Canada". In our first interim report in 2007, the Committee identified overarching questions, including how to define the senior years. We identified the categories of the young-old, middle-old and frail-old, categories which have arisen on a number of occasions in the testimony before us. But do these categories do justice to the diversity among seniors?

Having travelled across the country to meet with seniors, it is abundantly clear that the diversity among seniors is vast. To focus only on the frail elderly would be to neglect the majority of people over 65 who continue to lead healthy, active lives. And to focus only on the frailty of the "frail elderly" detracts from the strengths of individuals in this group.

Clearly, there is much more that differentiates the vast array of people over 65 than unites them. So how do we write a report on aging? What is the common thread weaving through the lives of such diverse people?

As a starting point, they are united by being in an age category which defines them as seniors. This categorization plays a large part in defining the roles they are expected to play in society. Too often, the categorization of "senior" overtly or subtly limits the horizons of the possible. This is ageism.

1.1 Defining Ageism

Given the aging population of Canada, my number one recommendation is that the next "ism" we need to address as a federal government is to recognize ageism.

Laura Watts, National Director of the Canadian Centre for Elder Law Studies, Evidence, January 28, 2008

Ageism can be outright discrimination which strips people of their rightful place in society on the basis of their age alone. Ageism can also be more nuanced. It can be externally imposed on seniors through rules and policies. And it can be internally imposed, where

people try to comply with societal expectations by

limiting their own possibilities.

Self-adopted ageism is the idea that "I cannot do that at my age." For many seniors, the personal definition of "what I am capable of" may be one of the biggest barriers to overcome.

Ageism is defined as discrimination on the basis of age that:

- Makes assumptions about capacity;
- Removes decision-making process;
- Ignores older person's known wishes; and
- Treats the older adult as a child.²

Elaine Gallagher, Centre on Aging, University of Victoria

The Committee has heard that "a youthoriented society often lacks positive images of aging, thus growing older is viewed as something to be denied, avoided at all costs, and kept

hidden. A society that values the contributions and wisdom of the older person makes it easier for an older person to maintain his or her right to make his or her own decisions."³

Ageism is receiving attention at the international level. Social movements to combat ageism have emerged in Europe, Japan and Australia. The *Madrid International Plan of Action of Ageing*, 2002 set out a positive view of aging.

Ontario Network for the Prevention of Elder Abuse, Stop Abuse, Restore Respect: Response to Senate Interim Report: Issues and Options for an Aging Population,

May 9, 2008. Appendix A.

Butler, R. (1975). Why Survive: Being Old in America. Harper & Row: Philadelphia in Ontario Network for the Prevention of Elder Abuse. Stop Abuse. Restore Respect: Response to Senate Interim Report: Issues and Options for an Aging Population, May 9, 2008.

Madrid International Plan of Action on Ageing, 2002

Recognition of the authority, wisdom, dignity and restraint that comes with a lifetime of experience has been a normal feature of the respect accorded to the old throughout history. These values are often neglected in some societies and older persons are disproportionately portrayed as a drain on the economy, with their escalating need for health and support services. Although healthy ageing is naturally an increasingly important issue for older persons, public focus on the scale and cost of health care, pensions and other services have sometimes fostered a negative image of ageing. Images of older persons as attractive, diverse and creative individuals making vital contributions should compete for the public's attention. Older women are particularly affected by misleading and negative stereotypes: instead of being portrayed in ways that reflect their contributions, strengths, resourcefulness and humanity, they are often depicted as weak and dependent. This reinforces exclusionary practices at the local and national levels.

There is an ongoing need to foster a positive image of older Canadians which more accurately reflects today's seniors and recognizes their contributions to the family, the community and the economy. This requires us to identify and remove barriers, disincentives, and discrimination, as Rock Lefebvre of the Certified General Accountants Association of Canada told the Committee:

We must ease the stigma associated with the "senior" and the notion that 65 years of age magically equates to withdrawal from productive life. We would not call for the diminishment of rights and benefits but would call for the removal of barriers, disincentives and discrimination perhaps un-intentionally imposed.

Evidence, March 26, 2007

In its second interim report, this Committee proposed initiatives to raise awareness of the benefits of volunteering, lifelong learning, and physical activity. The Committee has been struck by evidence presented to it which suggests that, in some cases, seniors may not take full advantage of opportunities presented to them because of self-imposed ageism. Thus, it seems of critical importance to make significant efforts to counter this form of ageism and to emphasize that age should never hinder people from trying new things and stretching their potential.

1.2 Moving Toward a Positive View of Aging

It is difficult to talk about aging in a positive way in a society which fights aging so vigorously. We are assailed with advertising which promises eternal youth. Changing this view will take a concerted effort, as Judy Cutler of the Canadian Association for the Fifty-Plus (CARP) told the Committee:

Mindsets have to be changed if we are to go beyond our obsession with defying aging and youth-oriented society. There is nothing wrong with looking and feeling good, but it should not preclude a dynamic and productive society for all ages. Social attitudes and marketing practices that are based on ageism create demographic silos where age groupings are pitted against each other in the workplace, in health care and in the media. This situation must change.

Evidence, December 11, 2006

Society moves and changes. Over the past century, we have radically redefined the roles available to women. Women became "persons", accessing a full range of legal rights, including the right to stand for office. The *Canadian Charter of Rights and Freedoms* was developed to prohibit discrimination on many grounds, including age.

But it takes time to change perceptions. Several witnesses have identified the need for intergenerational initiatives to expose children and youth to active seniors. Intergenerational activities help younger people develop a healthier image of aging, and provide enriching experiences for all generations involved. Initiatives to facilitate such interaction are occurring throughout the country.

For example, the Neighbours For Peace Program in Vancouver brings together Grade 2 and 3 classes with a group of seniors in order to help children and seniors communicate on ways to promote peace and mutual understanding. These kinds of initiatives need to be supported so that future generations have a healthier appreciation for aging.

Showcasing Positive Aging: UVic's Masterminds Program

The Masterminds program at the University of Victoria is one way to address ageism. Organized by the UVic Retirees Association and the University's Centre on Aging, the program presents a series of lectures by retired professors to showcase the work they have done since retirement. The program has featured writers, artists, theologians, scientists and others. They talk about books they have written, plays they wrote or acted in and research projects they have spearheaded.

One of the core principles of the European Union's Healthy Ageing Project is that "Older people are an intrinsic value to society. Many older people live a most meaningful life and are a resource for society. They contribute to society, work in a paid or unpaid capacity as volunteers, care for family members and friends, and carry out informal work in organizations and associations."⁴

This vision of aging is similar to that which has been outlined by the ministers responsible for seniors at the federal, provincial, and territorial levels in Canada. Margaret Gillis of the Public Health Agency of Canada told this Committee:

At their ninth meeting in September 2006, FPT Ministers Responsible for Seniors endorsed the report *Healthy Aging in Canada: A New Vision, A Vital Investment*, and the background paper entitled *From Evidence to Action*. The report embraces a vision of healthy aging that values and supports the contributions of older people, celebrates diversity, refutes ageism, reduces inequities and provides opportunities for older Canadians to make healthy choices that will enhance their independence and quality of life.

Evidence, December 3, 2007

The Committee believes that this vision needs to be more widely communicated to Canadians. An educational campaign to fight ageism must be developed in cooperation with community organizations. Such a campaign needs to promote the concept of aging well. The Committee recommends:

Swedish National Institute of Public Health, *Healthy Ageing – a Challenge for Europe*, 2007.

1. That the federal government lead an aggressive public relations campaign to portray healthy aging and to present the benefits of staying active at all ages — in volunteer work, continuous learning and physical activity.

Proactive campaigns aimed at changing public perceptions of aging cannot change some of the underlying forms of discrimination to which some seniors are subject, however. Ensuring that older adults are afforded the respect of their individual rights as full members of Canadian society requires constant vigilance.

Well-intentioned efforts to keep the frail elderly safe have resulted in decisions made for seniors by others, decisions as intimate as where they are going to live. Increased vulnerability resulting from ageism has exposed too many seniors to forms of abuse and neglect. Competency assessments related to driving or working have relied on age rather than ability. It is to these areas that we now turn our attention.

1.3 Competency

I think it is no problem for people to be at risk if they have the capacity to understand their risk. If they know that they are doing something that is high risk behaviour, or that they are putting themselves at risk to do it, and they fully understand and appreciate the consequences of that behaviour, then absolutely, they have that right to risk.

Marge Dempsey, Acting Chief Executive Officer, Alzheimer Society of Niagara Region, *Evidence*, May 9, 2008

In our second interim report, the Committee explored options to allow people to age in the place of their choice. A key condition for this to happen is that we acknowledge and respect the choices that seniors make. Yet the Committee has heard that too many seniors "are not being taken seriously, that others are taking control of their lives and taking away their rights to make their own decisions, testing

their capacity and their competency when in fact they are totally competent." ⁵

Laura Watts of the Canadian Centre for Elder Law Studies outlined for the Committee the enormous social and civil impacts of a challenge to capability:

If a person is determined "incapable," he or she loses the right to vote, the right of liberty, the right to marry — or in some cases, the right to divorce. That person loses the right to make guardianship and asset decisions. The person becomes a nonentity in law. It is the most severe impact one can have and if we do not understand what our terms mean, the impacts indeed are desperate.

Evidence, January 28, 2008

Currently, declaring someone incompetent is too often an all-ornothing proposition. As Maureen Etkin of the Ontario Network for Prevention of Elder Abuse told the Committee, "a senior may be able

to decide where they wish to live, but not able to make decisions about managing their finances. This is a confusing area for seniors and service providers. There is a definite need for more research into best practice in this area."

The complex issue of competency determination requires sound evidence on competency. The Committee has heard that we do not yet know enough about how to measure mental competency, mental capability and mental capacity and that there is a need for more research on these issues. The knowledge gaps in this area need to be identified in consultation with the professional groups who would use this knowledge.

I suggest that the appropriate question in Canada should be: "Capable for what?". If we address this notion as a standard starting ground, the lexicon can unfold from there as opposed to giving a blanket statement about a number of unknown issues.

Laura Watts, National Director, Canadian Centre for Elder Law Studies

Judith A. Wahl, Executive Director, Advocacy Centre for the Elderly, *Evidence*, May 28, 2007.

The Committee recommends:

2. That the Canadian Institutes of Health Research fund research on mental competency, mental capability and mental capacity. The research should be driven by the information needs of policy-makers and licensing bodies to lead to the development of guidelines based on research evidence.

Educating Canadians about the importance of advance planning should be an integral part of prevention programs on elder abuse, and the federal government should incorporate such education in its efforts to address elder abuse. Because capacity assessments have such significant impacts on people, it is essential to ensure that they are being consistently and methodically carried out in all jurisdictions. The federal government needs to play a leadership role in determining what tools and mechanisms would be appropriate for creating capacity assessments.

Despite the significant implications of being judged "incapable", the Committee has heard many Canadians do not give serious attention to planning for this situation and to designating an appropriate power of attorney. Dr. Duncan Robertson of the BC Medical Association suggested that:

Thinking ahead and making arrangements with respect to financial management and health care decisions are ways of protecting oneself...Failure to make those advance planning decisions renders people vulnerable.

Evidence, June 5, 2008

The federal government needs to play a leadership role in determining what tools and mechanisms would be appropriate for creating capacity assessments.

The duties and responsibilities under a Power of Attorney may be very poorly understood. Power of Attorney fraud is one of the fastest growing areas of crime in Canada.⁶

Education on the implications of Power of Attorney is key to allowing

people to protect themselves from abuse.

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Canadian Centre for Elder Law, Frequently Asked Questions at http://www.ccels.ca/forolderadults.htm.

This is done by different organizations across the country. The Advocacy Centre for the Elderly in Toronto provides a good example of advocacy and education on legal issues confronted by seniors. Educating Canadians about the importance of advance planning should be an integral part of prevention programs on elder abuse, and the federal government should incorporate such education in its efforts to address elder abuse.

A Community Legal Clinic with a Focus on Elder Law

Opened in 1984, The Advocacy Centre for the Elderly in Toronto concentrates on elder law. In addition to public legal education, the clinic provides a broad range of services. The greatest demand is for advice and advocacy on issues related to mental capacity problems from the senior's perspective; advocacy on health law issues; access and eligibility to home care and long-term care systems; conflicts around discharge from hospital; mental health problems, particularly those related to access to home care; long-term care; and advice and representation on elder abuse issues, which include abuse of power of attorney, fraud, misuse of authority, financial abuse, physical abuse and neglect.

1.4 Competency and Driving: Not Just a Seniors Issue

The majority of unsafe drivers on the road are not unsafe because they are old or sick; they are just not safe drivers.

Dr. Briane Scharfstein, Associate Secretary General of the Canadian Medical Association, *Evidence*, January 28, 2008

Age is not a proxy for competency. Issues such as mandatory retirement and the safety of older drivers capture the public imagination; but, is it appropriate to focus on age in these questions? There are age-related declines in some areas for most people, but these do not occur at the same rate for all individuals.

If age is not, in and of itself, an indicator of ability, then we must develop innovative approaches to ensure that fully capable people are not stripped of their lifelong professions or privileges such as driving. This needs to be balanced against the need to ensure public safety.

Most older drivers are among the safest drivers on the road. Increasing accident rates among seniors are explained by the higher prevalence of medical illness, medication use, and associated impairments for *some* older drivers.

When it becomes necessary, many older drivers impose restrictions on their own driving, such as avoiding driving at night. Although medical conditions that affect one's ability to drive can happen at any age, older drivers are more likely to have certain medical conditions which force them to change their driving habits, including dementia. Research has found that drivers with dementia, however, significantly overestimate their driving competence compared to healthy older drivers. Such drivers may not be able to self-regulate their driving – which makes it necessary to establish formal mechanisms to protect these individuals and the public.

The decision to stop driving is one which is made with great difficulty by seniors, their family members, and their physicians. In Canada, most provinces require physicians to report patients who may be medically unfit to drive. Although guidelines are available, such as the Canadian Medical Association's *Guidelines for Physicians in Determining Medical Fitness to Drive*, physicians have told the Committee that the conversation about driving cessation is one of the most difficult ones a family physician will have with a patient. According to Dr. Shawn Marshall, Associate Professor at the Rehabilitation Centre, Ottawa Hospital:

The physician-patient relationship is often negatively affected. Clearly, you have some conflict. You are an advocate for the patient, yet, under law, you are required to report the patient as possibly unfit to drive. In addition, physicians have identified repeatedly through surveys that they have limited knowledge and education to make decisions. There is also lack of evidence-based information upon which to make these decisions.

Evidence, January 28, 2008

Research is currently under way in Canada, looking into questions such as determining at what point a diagnosis that *may* affect an individual's ability to drive develops into a functional

Phoebe Dey, "Taking Away the Keys," Express News, University of Alberta, 13 June 2003.

impairment that affects their ability to drive. The CanDRIVE Research Network is an example of this research.

CanDRIVE Research Network

Funded by the Canadian Institutes of Health Research, the CanDRIVE research network conducts research related to prolonging safe driving periods for older drivers. The network brings together researchers, seniors groups, clinicians, ministries of transportation and other governmental and nongovernmental agencies, so that research evidence can be translated into practice.

The Committee has heard that making our roads safer does not require a focus on seniors. As Dr. Michel Bédard, Canada Research Chair in Aging and Health at Lakehead University, told the Committee:

We need to employ safer driving techniques, and perhaps even take a driver's refresher course every five years. People talk about periodic testing, but not about making people take the occasional new course. It is important to adopt a comprehensive approach to dealing with this issue.

Evidence, January 28, 2008

The Committee has received innovative proposals on ways to balance public safety and the rights of individuals. For example, the Canadian Automobile Association (CAA) has recommended that governments introduce conditional licences for drivers who have reduced physical abilities that will affect their driving skills. This would provide these individuals with the opportunity to continue driving with restrictions rather than losing their licences altogether. Restrictions might include certain hours, certain types of highways, or driving aids.

The CAA has identified a number of other issues which would make the roads safer, including improvements to road and highway design that make safe navigating and manoeuvring easier, not just for seniors, but for all drivers; changes in vehicle design to accommodate the physical challenges of aging; and road safety education that includes and addresses the specific needs of aging drivers and their families. These issues will be explored further in Chapter 4, on age-friendly cities.

National Blueprint for Injury Prevention in Older Drivers

The Public Health Agency of Canada is providing funding to McGill University and the Canadian Association of Occupational Therapists for a program called the National Blueprint for Injury Prevention in Older Drivers. This blueprint is looking at developing a strategy for evaluating the best evidence for prolonging the safe driving period, with a special focus on driver refresher courses. Findings will be communicated to various stakeholders.

As a society, we will have to rely on multiple approaches, including the promotion of safe driving and the development of alternative forms of transportation to meet the mobility needs of coming older generations. Flexibility and innovation in the conception and implementation of those approaches will be necessary to meet the needs of older adults living in urban and rural areas. The Committee urges the federal government to take a leadership role in such initiatives.

As the research which is currently under way improves the evidence on which decisions can be based, the Committee recommends:

3. That the federal government take a leadership role in federal-provincial-territorial initiatives to address public safety and retirement from driving in a way that is dignified, and that provinces and territories take a leadership role in education and enforcement around the medically-at-risk driver in partnership with other agencies.

1.5 Competency and Work

The majority of workers withdraw from the work force long before they are forced to do so by functional decline. Professional organizations, such as the Canadian Medical Association, have established systems of ongoing evaluation.

Dr. Michel Bédard, Canada Research Chair in Aging and Health, Lakehead University, *Evidence*, January 28, 2008.

Competency for Canadian Physicians - Ongoing Evaluation

The Canadian Medical Association works from the premise that one's competence can be affected by illness and adversity at any stage in one's career and is not specifically reflected in age. Although there may be increased scrutiny in some programs linked to age, the Canadian Medical Association recognizes that age is only one of a multitude of factors. The processes that ensure competence apply throughout the physician's life.

Physicians who practice in institutional settings — predominantly hospitals — adhere to a rigorous process to maintain quality and competence. Rather than having physicians either completely in or out

of practice, privileges can be varied over time or linked to declining competency in certain areas — again, avoiding a set age-restriction requirement to leave practice.

There has been rapid change in legislation across the country in regards to mandatory retirement. Over the life of this Committee, several provinces have eliminated mandatory retirement. Nova Scotia will become the last province to eliminate mandatory retirement when legislation comes into effect in that province in July 2009. In most provinces, it is now prohibited

Eligibility to continue to work should be based on competency, not on some magical age.

Gloria Gutman, Professor, Gerontology, Simon Fraser University

to force someone to retire unless it constitutes a bona fide occupational requirement under the law.

Federally regulated employees fall under the purview of the Canadian Human Rights Act (CHRA), regardless of the province of work or residence of the employee. The Canadian Human Rights Act expressly excludes those who have "reached the normal age of retirement" from protection against discrimination in the workplace. As a result, in July 2009, federally regulated employees will be the only employees in Canada not protected from mandatory retirement. Although there is no generalized mandatory retirement age in the public service, this may not be the case for other federally regulated employers.

The Committee shares the view of Canada's Association for the Fifty-Plus (CARP) that "it is a human right for Canadians to have choice about when to retire based on ability and not on age" and recommends:

4. That the provisions of the Canadian Human Rights Act concerning mandatory retirement be amended to bring federal legislation in line with other human rights legislation in Canada.

1.6 Abuse and Neglect

The World Health Organization's *Toronto Declaration on the Prevention of Elder Abuse* defines abuse as follows:

Elder Abuse is a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person. It can be of various forms: physical, psychological/emotional, sexual, financial or simply reflect intentional or unintentional neglect.⁹

Gail Mackenzie-High of the Niagara Elder Abuse Prevention Network¹⁰ presented the Committee with a composite story of Rosa to highlight the many forms of abuse.

Rosa's Story

Rosa is a 79 year old woman, suddenly widowed less than a year, from her marriage of 55 years. Her income, which was largely dependent upon her husband's private pension, has been significantly reduced. Her home is in need of regular maintenance, bills have been piling up and Rosa is feeling overwhelmed. She has socially withdrawn from her previous activities due to financial worries and emotional exhaustion. She does not want to move from this, her marital home.

World Health Organization, The Toronto Declaration on the Prevention of Elder Abuse, 2002.

Gail Mackenzie-High, Chair, Niagara Elder Abuse Prevention Network, Evidence, May 9, 2008.

Her adult son moved in with her in an effort to offset costs and assist her with maintenance of her home. A community agency is called by neighbours, reporting that they often hear the son yelling and swearing, threatening to have his mother placed "in a home". In meeting with Rosa, agency staff observes that she appears to have some difficulty with her memory, although it is unclear as to whether this is the result of actual cognitive impairment/decline, or a reactive depression related to the recent loss of her spouse and to her current situation.

Rosa reveals that her son has a history of sporadic employment and that she now suspects that he may have a substance abuse issue and perhaps a gambling problem. He denies this and thus refuses any assistance / help in this area. Rosa gives money to her son to buy groceries for her, but little food is found in the house when agency staff visit and Rosa reports that no change ever comes back from his shopping.

Rosa wants help but expresses fear that if she asks her son to leave she will not be able to stay in her home, and fears her only choice will be long term care placement. She chooses to take no action at the time. Weeks later, Rosa presents to hospital with a fractured wrist, and upon physical examination the physician notices bruising that is inconsistent with her explanations of their cause. With careful probing by hospital staff, Rosa reveals that her son has been "pushing her around" and the police are notified.

Further investigation reveals that her assets have indeed by now been depleted, and she may not be able to maintain living in her home for much longer.

While charges will be laid against the son, Rosa has lost her ability to age in the place of her choice. She has lost her ability to be involved in activities of her choosing, and she has lost her relationship with her son. An able person who only a year ago believed she had control of her choices, found herself in a position of having inadequate income, suffering loss of trust, and in a position of imminent financial loss.

As Rosa's story indicates, there are many forms of abuse. In some cases, the abuse is a continuation of violence which has occurred throughout a person's life - a woman who has been abused for much of her adult life will not suddenly be safe when she turns 65 years old.

Older women are at greater risk of abuse due to increased social isolation, cultural norms, familial status, disadvantage or disability.¹¹

At other times, the abuse begins in the senior years. Abuse and neglect of older adults can occur at home, in the community, or in institutional settings. It can take many forms.

Although some seniors fall victim to fraudulent behaviour on the part of strangers, most abuse comes from people in positions of trust who are well known to the senior, such as other family members.

The different forms of abuse call for different interventions. Seniors are, after all, adults, and as Marion Smith told the Committee "seniors who are abused by family members don't want to be separated from them, they just want the abuse to stop." Fewer than one in five situations of abuse actually come to the attention of any public agency, and fewer still come to the attention of a public agency operating in the criminal justice system.

The Committee has heard that what is needed to address elder abuse is not new laws, but better enforcement of existing laws and enhanced supports to seniors.

Shelter for abused seniors

Kerby Rotary House in Calgary is the first shelter in North America for abused seniors. It offers safe, secure shelter to older men or women over 60 years of age in Calgary and area, who are experiencing family abuse in their lives. The shelter provides crisis intervention, support, advocacy, referral, short-term housing and the necessities of daily life.

On occasion, the abuse might arise due to an inability on the part of caregivers to cope with the many stresses of providing care. While the stress of providing care is real, it never justifies an abusive response. This report outlines options to address caregiver issues in Chapter 6.

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M. Etkin, Appendix A, The Ontario Network for the Prevention of Elder Abuse: Stop Abuse, Restore Respect, Appendix A.

Ouestionnaire submitted by Marion Smith on October 16, 2007.

Alison Leaney, Canadian Network for the Prevention of Elder Abuse, *Evidence*, May 28, 2007.

Abuse and neglect in institutional settings may arise because of staffing shortages or lack of appropriate training for staff. This must never be tolerated. Staff must be trained to recognize abuse, and be provided necessary education and support to do their job well. An innovative approach which was developed in France to help a facility address abusive behaviour by staff is worth noting:

Together Against Abuse

In France, the Résidences Santé Cousin de Méricourt and Services de l'Aqueduc residential facilities won the City of Paris' Special Jury Prize in 2005 for better care initiatives, as set out in their paper, "Ensemble contre la maltraitance." They recommended an educational approach whereby staff members do self-evaluations in order to identify their own good and bad practices. Their approach promotes collective detection as all staff members are treated identically. 14

Seniors and groups across the country have highlighted the importance of public education around senior abuse. Seniors organizations which have met with the Committee have identified educational and programs which have outreach they sponsored to educate their members on abuse, and particularly, on how to protect themselves from abuse. These organizations have all expressed particular concerns for isolated seniors, who have no regular contact with formal organizations. The Committee has not been able to identify solutions to this challenge, but highlights the importance of personal outreach to these seniors - either through the professional and public services they receive, or through the work of the voluntary sector.

There is a huge underrecognition of abuse of seniors in Canada. I would say that this field is 20 years behind where we were when we were trying to raise awareness about violence against women and, before that, how to prevent and respond to abuse of children.

Alison Leaney, Canadian Network for the Prevention of Flder Abuse

¹⁴ Marie Beaulie, Brief on the Living Conditions of Older Adults, Elder Abuse – 20 Years of Preoccupation in Quebec: Reflections on the Progress to Date and Avenues to be Explored with a View to Finding Solutions Suited to Our Society, September 2007.

The Committee emphasizes the importance of supporting the organizations that work on abuse issues at the community level, the provincial-territorial level and the national level.

To detect abuse in seniors, workers across all sectors need some appreciation of the aging process and knowledge of the indicators of abuse or neglect. The brief submitted by Maureen Etkin of the Ontario Network for the Prevention of Elder Abuse emphasized the importance of training:

It is important to identify those groups most likely to interact with seniors such as pharmacists, physicians, personal support workers, etc. and work towards a standardized curriculum on senior abuse. Personal support workers (PSW) are one of the largest groups to interact with seniors in their homes and maybe the only contact the senior has with the broader community. The close individual care that a PSW provides offers an opportunity to develop a relationship of trust with the senior. As a result seniors may first confide in this person about abuse. ¹⁵

The Committee is pleased that the federal government is supporting efforts toward this. In June 2008, the Government announced that the federal government plans to create training materials to support national professional associations in adapting and creating their own materials and tools for their frontline workers (e.g., health, legal, police, and financial professionals who work with seniors) in spring 2009, to help them identify and address the elder abuse situation. Federal employees also come into direct contact with seniors. Since personal contact with seniors has been repeatedly identified as the best way to educate seniors about abuse, the Ontario Network for the Prevention of Elder Abuse is currently engaged in a project where it is providing some training to some staff at Service Canada on elder abuse. The Committee recommends:

http://news.gc.ca/web/view/en/index.jsp?articleid=405179.

¹⁵ Ontario Network for the Prevention of Elder Abuse, *Response to Senate Interim Report: Issues & Options for an Aging Population.*

5. That the federal government increase support for research into abuse and neglect issues; work closely with community organizations to avoid the duplication of efforts and to meet identified needs; and make information about abuse and neglect available in federal government staff training.

1.6.1 New Immigrant Seniors and Abuse

Witnesses testifying before the Committee identified immigrant seniors arriving in Canada under the family class category as a particularly vulnerable group. The Committee heard that these seniors faced an increased risk of abuse and neglect due to the financial dependency associated with the Government of Canada's sponsorship policy. Immigrant seniors arriving as parents or grandparents under the family class category must undergo a period of sponsorship that lasts ten years, in which their sponsor is responsible for their basic daily living requirements such as food, shelter, clothing, as well as other personal requirements.

During this ten year period, sponsored parents, or grandparents are also not entitled to any form of social assistance, including Old Age Security, or the Guaranteed Income Supplement, regardless of whether Canada has signed a reciprocal social security agreement with their country of origin, or not.¹⁷ In addition, Citizenship and Immigration Canada's *Sponsorship Agreement* states that elderly parents or grandparents are not expected to look for a job to care for themselves.¹⁸ As a result, during the first ten years following immigration, between 25-40 percent of seniors who arrive in Canada after the age of 60 have no independent source of income and are completely dependent financially upon their sponsors.¹⁹

Witnesses before the Committee testified that this sponsorship arrangement creates a situation of dependency in which immigrant seniors could become susceptible to abuse or neglect.²⁰ In her

²⁰ Ibid.

¹⁷ A reciprocal social security agreement may however entitle sponsored immigrants partial pension benefits from their country of origin.

Rell Deshaw, "The History of Family Reunification in Canada and Current Policy," *Canadian Issues*, Spring 2006, p. 15.

Brief to the Special Senate Committee on Aging: Second Interim Report. Dr. Sharon Koehn, Centre for Healthy Aging at Providence, June 4, 2008, p. 1.

testimony, Dr. Sharon Koehn articulated that there were two main factors related to sponsorship that increased the likelihood of abuse or neglect.²¹ First, the lengthy period of sponsorship poses a risk because during that time period, the financial status of the sponsor may decline unexpectedly, resulting in financial hardship on the sponsor and his family. Further, the health of the sponsored senior could also rapidly decline during that period, resulting in an increased burden on the family due to informal care giving needs. Financial hardship coupled with an inability to cope with the health needs of the sponsored senior could contribute to abuse or neglect, as well as sponsorship breakdown.

Second, the dependency associated with sponsorship creates power imbalances within families, which can result in abuse and exploitation. This occurs when sponsors expect their parents or grandparents to compensate them in some way for agreeing to support them for the ten year period. The Committee heard that parents and grandparents are often expected to take care of grandchildren, do the housework and cook, which they are sometimes unable or ill-equipped to do. Other forms of exploitation include not directly accounting for the employment of sponsored family members in family-owned businesses, which means that seniors are then unable to accumulate Canadian Pension Plan benefits. Finally, the Committee also heard that sponsored seniors, particularly in British Columbia, sometimes end up working on fruit farms under poor working conditions for low wages to pay back their families and prevent themselves from being "a burden on the children".²³

Though the *Sponsorship Agreement* provides immigrants with recourse in cases of abuse both in terms of social assistance and the recovery of sponsorship debt, this option is often not pursued due to an unwillingness to bring shame upon their family.²⁴ Recent sponsored immigrants tend to have limited knowledge of their rights due to

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²¹ Dr. Sharon Koehn, Centre for Healthy Aging at Providence, *Evidence*, June 4, 2008.

Dr. Sharon Koehn, Centre for Healthy Aging at Providence, Evidence, June 4, 2008.

²³ Charan Gill, Progressive Intercultural Community Services Society, *Evidence*, June 4, 2008.

²⁴ Brief to the Special Senate Committee on Aging: Second Interim Report, Dr. Sharon Koehn, Centre for Healthy Aging at Providence, June 4, 2008, p. 2.

language and cultural barriers and therefore fear the consequences of sponsorship breakdown.²⁵

Consequently, in order to reduce the risk for abuse and neglect in sponsorship arrangements, witnesses advocated that the period of sponsorship for family class immigrant seniors be reduced from 10 years to 3 years, in line with the time required to become a Canadian citizen. This recommendation is consistent with the Government of Canada's 1997 decision to reduce the period of sponsorship for spouses and partners from 10 years to 3 years in recognition of the potential for abuse in sponsorship arrangements. ²⁷

Witnesses also noted that a reduction in the sponsorship period would require changes to the residency requirements of Canada's public pension schemes.²⁸

In order to reduce the risk of abuse or exploitation of parents or grandparents arriving as immigrants under the family class, the Committee recommends:

6. That the government reduce the immigration sponsorship period from ten years to three years similar to the regulations pertaining to conjugal sponsorship, and make a commensurate reduction in the residency requirement for entitlement to a monthly pension under the Old Age Security Act.

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²⁶ Brief to the Special Senate Committee on Aging: Second Interim Report, Dr. Sharon Koehn, Centre for Healthy Aging at Providence, June 4, 2008, p. 9.

Rell Deshaw, "The History of Family Reunification in Canada and Current Policy," Canadian Issues, Spring 2006, p. 12.

Brief: Brief to the Special Senate Committee on Aging: Second Interim Report, Dr. Sharon Koehn, Centre for Healthy Aging at Providence, June 4, 2008, p. 2.

Chapter 2: Integrating Care

Most Canadians want to stay in their communities as they grow older. Others want to move closer to family and friends, or to communities which provide the retirement environment they seek. Some choose to stay in their own homes, while others want to move into housing that requires less maintenance or provides supports to daily living. The choice available to seniors depends on many factors, including their health status; where they live in Canada; whether they live in an urban or rural area; whether they have the support of family and friends in the vicinity; and their financial situation.

Various supports which make it possible for all seniors to have viable choices about where they live. These include housing and renovation programs, supportive housing options, home care, and palliative care.

Too many older people across the country are not being well served by this continuum of supports to age in place of choice. A health system designed to deal with episodic illness is ill prepared to deal with the rise in chronic illness associated with an aging population. The frontline workers the Committee has met caring people. Thev innovative solutions to help people have the highest possible quality of life. But there are times when the wrong decisions are taken because of a lack of viable alternatives. At other times, the various health and social service systems are not sufficiently integrated to allow It is impossible to separate health services from social services. Hospital services cannot be separated from home care services because for the people on the front line, there simply is no distinction between them.

Dr. François Béland, Professor, Université de Montréal

caring professionals and family members to pull together the right basket of services to meet the needs of ailing seniors. Witnesses from across the country have called for moving toward a system of care which would put in place the right services at the right time so that people can age in the place of their choice. Witnesses have asked for help to navigate the complex systems of care – but the Committee has heard that what is needed is much more than simple navigation, as Marcus Hollander of Hollander Analytical Services pointed out:

The person needs someone to advocate, not just navigate, because then you might be dealing with different organizations saying they will look after this person or they cannot because of this reason, and so on. They must be able to authorize services.

Evidence, April 7, 2008

Services have to be designed so that people don't fall through the cracks, and so that there are smooth transitions as their needs Policy-makers and academics refer to such a system as integrated care. The Committee received overwhelming support for a move toward integrated care as it travelled across Canada.

2.1 A Move to Integrated Care

While seniors with significant functional disabilities, or frail seniors, represent a minority of the elderly population, they are

> disproportionate users of acute hospital and nursina home and have frequent care

transitions between the two.

Seniors have a range of care needs that cut across both health and social services. Ideally, one would like to have a system of care that is specifically targeted to meet this diverse set of needs...

> Marcus J. Hollander. Hollander Analytical Services Ltd.

For frail seniors, there is no distinction between health-care services and services, between being "treated" and receiving "care" in the community and at home. Social and health-care services are complicated and difficult to navigate, at the very time when older people have the least energy to cope with making use of them. Ensuring that these services are integrated is not an administrative or financial requirement, but rather a necessity

The committee has heard that, currently, despite for frail seniors. effort and reforms, services for seniors remain fragmented:

- Transitions between institutions and care providers are difficult;
- The complex process of planning the services remains the responsibility of seniors and their families; and
- Multiple forms of obtaining funding and making payments, and varying conditions for eligibility for social and health-care

services, complicate management of access to the required services further.²⁹

In addition, there are types of services which are missing from the ideal basket of services which would be required by seniors. This results in inappropriate use of the health care system. Dr. Duncan Robertson of the BC Medical Association provided the following example:

Our system is missing post-acute, step-down care for those individuals who may take a month or more in a properly structured environment in order to recover from an episode of delirium that they had in hospital or a fall and fracture. In the absence of those resources in sufficient numbers, decisions are made prematurely and inappropriately, often to bypass the option of potentially returning home and going into permanent facility care.

Evidence, June 5, 2008

Integrated, coordinated care to persons with chronic care needs allows health and social services to mobilize a range of resources quickly to meet needs as they arise, thus avoiding using resources inappropriately.

This requires "a broad range of services, a single administrative authority, a single budget, and the ability to have someone advocate on behalf of the client and help them go through that system."³⁰

An ideal funding system would have decision-making powers to make budgetary trade-offs toward preventative measures. Dr. François Béland, Professor at the Université de Montréal, gave the following example of how such a system would work, referring to an insole which has been demonstrated to reduce falls among seniors:

The thinking would go something like this: 1) some frail seniors are prone to falling; 2) each time a senior has a fall, it results in hospitalization costs in the order of "X," a far from insignificant amount; 3) if 50 percent of all falls

Marcus J. Hollander, President, Hollander Analytical Services Ltd., *Evidence*, April 7, 2008.

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This paragraph is a direct citation from the brief of Francois Béland "Three focal points for a policy: health, services and innovation."

could be prevented with the help of this insole, then it is worth supplying this insole to persons at risk of falling; therefore 4) persons at risk will be outfitted with this insole under the terms of a health care protocol.

Evidence, April 7, 2008

Shifting a system as large as the health care system to better meet the needs of all Canadians with chronic health care needs is a monumental task, but it is not impossible. The Committee has heard that comprehensive, integrated provincial systems of care have existed previously in Canada³¹. Many other countries are trying to move toward more integrated models of care as well.

Integrated Care in Europe

In Europe, and in other developed countries, integrated care is seen as key to improving accessibility, quality and financial sustainability. The Care Management of Services for Older People in Europe Network (CARMEN) is funded by the European Commission to advance ways in which integrated health and social care can be achieved in EU countries. One of the products of the Network was the development of a policy framework for integrated care for older people. ³²

The federal government can play an important leadership role in supporting a move toward integrated care. Witnesses pointed to the Health Transition Fund (1997-2001) and the Primary Health Care <u>Transition Fund (2000-2006)</u> as an example of the role the federal gay is maintained and play to build momentum toward change.

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³¹ Ibid

³² Margaret MacAdam. *Frameworks of Integrated Care for the Elderly: A Systematic Review*, Canadian Policy Research Networks, April 2008, p. 20.

primary health care delivery.

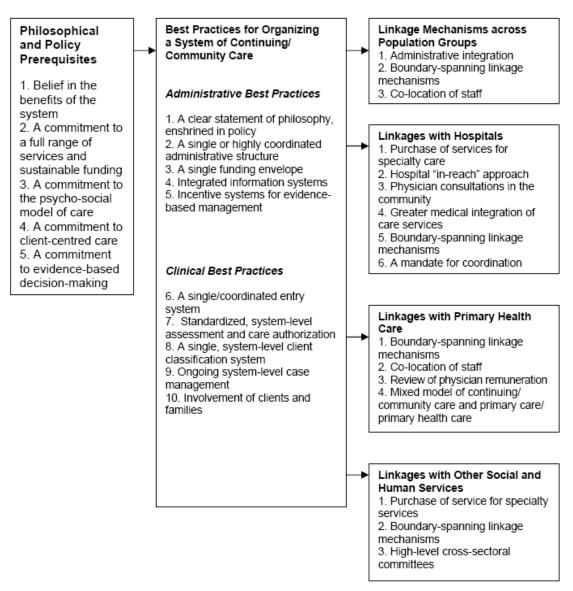
Witnesses emphasized that "there is an opportunity for the Government of Canada to continue the momentum across Canada and hasten the fundamental changes required to sustain the Canadian health care system," and in particular, to move toward greater integration of care.

The components of a system of integrated care, including health care, housing, long-term care, supportive housing/ assisted living, home care, and respite care, are areas of provincial jurisdiction. It is not possible to have a single integrated services model. However, research has identified best practices for organizing systems of continuing care services, including administrative and service delivery best practices. The framework developed by Dr. Marcus Hollander (Table 1) was recommended by several witnesses.

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³³ Dr. François Béland, Professor, Université de Montréal, April 7, 2008.

Table 1
A Best Practices Framework for Organizing Systems of Continuing/Community Care Services



Source: Hollander, M. and M. Prince, "Organizing healthcare delivery systems." Healthcare Quarterly Vol. 11, No. 1: 44-54 in Margaret MacAdam, Frameworks of Integrated Care for the Elderly: Systematic Review, Canadian Policy Research Networks, April 2008.

The Committee agrees with Dr. François Béland of the Université de Montréal that it is time to "look at integrating services from the standpoint of meeting the needs of frail seniors, not in terms of the

of departments, regional organizations, hospitals, CLSCs or home care services."34 The integration of health and social systems is complex, in part because the health services required by seniors need to continue to be part of universally funded services under the Canada Health Act, while some of the other services are covered under various other payment schemes, including some with copayment or eligibility criteria. Several witnesses referred to these administrative challenges. Donald Juzwishin, Executive Officer of the Health Council of Canada, explained that:

If federal money is to fund any such programs one day soon, then one of the objectives with home, community and long-term care ought to be that as long as the total cost is less than the cost to the government of a long-term care facility, then people ought to have the right to remain independent.

Sharon Sholzberg-Gray, Canadian Healthcare Association

There are all kinds of financial incentives that actually keep people from doing the right thing or encouraging people to stop doing many things that may not necessarily, based on evidence, be all that effective... To achieve the kind of integrated community setting we would like to have, it is necessary to take a hard look at the disincentives found in the system. If you put the incentives in place, the other will follow. People will generally follow the money and that will be a fairly strong incentive for you to be able to put into operation.

Evidence, April 7, 2008

It is important to identify the disincentives which are in place which make it so difficult for our health and social service systems to provide the kind of care which Canadians with chronic care conditions need and want.

The federal government is well placed to play a leadership and coordination role with the other jurisdictions to create incentives to support a move toward integrated, coordinated care across the country. The BC Medical Association reported that international

³⁴ Dr. François Béland, Professor, Université de Montréal, *Evidence*, April 7, 2008.

experience demonstrates that even the most well-researched and proven initiative will be difficult to implement widely unless the start-up costs of home and community care programs are adequately budgeted.³⁵ The federal government can help provinces meet these start-up costs.

The Committee recommends:

7. That the federal government develop a federal initiative which would provide financial support to the provinces to facilitate the move toward integrated models of care for the elderly as a model for quality care for all ages.

The objectives of the program should be designed to ensure:

- Integration of a broad domain of services, including, but not limited to, health care, case management, home and community services, and residential care services;
- Improved access to comprehensive care;
- Increased emphasis on health promotion, disease prevention and chronic disease management;
- Expanded multi-disciplinary teams so the most appropriate care is provided by the most appropriate provider;
- Increased emphasis on one-stop-shopping for seniors and their families; and
- Improved portability of services between provinces, including reciprocal agreements to eliminate waiting periods for services.

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BC Medical Association, Bridging the Island-: Re-building BC's Home and Community Care System: A Policy Paper by BC's Physicians, May 2008.

2.2 Continuum of Services and Care for Aging in the Place of Choice

Allowing people to age in the place of their choice requires a continuum of supports and care services which respond promptly to individuals as their needs change. The integration of these services, as outlined above, is essential. The individual components along this continuum of care must also be strengthened, from housing, to supportive housing residential care, to home care services and palliative care.

The high end of the market, the condos, will always look after the high end. It is the rest of Canadians we have to be concerned about, those who for whatever reason are not in a position to be able to afford a condo.

Ian Scott, Seniors College of Prince Edward Island

2.2.1 Housing

The vast majority of seniors live in private homes. For many, this is feasible without additional supports. Others will require help. As a society, this will mean growing demands for home adaptations to enable aging in place. It will also mean increased amounts for home maintenance and support services, including home care and personal care from family, friends and neighbours.³⁶

Sometimes, seniors have to make the difficult decision that their current housing situation no longer meets their needs. The Committee has identified a number of recommendations to ensure that seniors are able to grow older in housing that meets their changing needs.

2.2.1.1 Home Adaptations

In an ideal world, homes would be designed in such a way that they could adapt to changing needs throughout life. While universal design principles should be incorporated in future homes and neighbourhoods, the majority of today's homes need to be modified to adapt to the changing needs as people age.

Luis Rodriguez, Senior Researcher, Canada Mortgage and Housing Corporation, *Evidence*, December 10, 2007.

High repair and maintenance costs can place a heavy burden on low-income seniors. Luis Rodriguez of the Canada Mortgage and Housing Corporation told the Committee that:

This can be a particular problem in areas outside urban centres, where home ownership rates for senior households are high — 82 percent compared to 68 percent in urban centres — and the overall housing stock is much older, with 34 percent built before 1961, than it is in urban centres, with 29 percent built before 1961. Aging in place on an inadequate income, whether in a rural or urban area, can result in overall deterioration of housing and neighbourhoods through neglect of repairs and maintenance.

Evidence, December 10, 2007

The Canada Mortgage and Housing Corporation (CMHC) provides funding to help low-income seniors adapt their homes, through the Residential Rehabilitation Assistance Program and the Home Adaptations for Seniors' Independence Program.

Integrated Care in Europe

In Europe, and in other developed countries, integrated care is seen as key to improving accessibility, quality and financial sustainability. The Care Management of Services for Older People in Europe Network (CARMEN) is funded by the European Commission to advance ways in which integrated health and social care can be achieved in EU countries. One of the products of the Network was the development of a policy framework for integrated care for older people.³⁷

Although the CMHC identified a wide range of approaches they use to tell Canadians about these programs, Sharon Sholzberg-Gray of the Canadian Healthcare Association echoed a common concern this Committee heard about the renovation programs: "These programs are important, but many seniors are not aware of their existence. If

Douglas Stewart, Vice President, Policy Planning, Canada Mortgage and Housing Corporation, Evidence, December 4, 2006.

they did, would there be enough resources for all of them to access those programs?"³⁸

Many witnesses have emphasized the importance of one-to-one contact in relaying information to isolated seniors. Given the important role that housing can play in keeping seniors healthy and allowing them to age in the place of their choice, the Committee urges the Canada Mortgage and Housing Corporation to broaden its efforts to publicize the Residential Rehabilitation Assistance

The Committee urges the Canada Mortgage and Housing Corporation to broaden its efforts to publicize the Residential Rehabilitation Assistance Program and the Home Adaptations for Seniors' Independence Program.

Residential Rehabilitation Assistance Program and the Home Adaptations for Seniors' Independence Program. Furthermore, CMHC and non-profit organizations and professional groups which have direct contact with seniors must work together to insure information about these programs are communicated to all seniors, especially those who may be socially isolated.

2.2.1.2 Housing affordability

One of the most pressing housing issues facing seniors is housing affordability. In some cities, such as Vancouver, low-income seniors are unable to access the rental housing market or they spend a disproportionate amount of income on housing. In rural areas, the Committee has heard that low-income seniors are unable to keep up with the maintenance costs of the homes they own. Many seniors have a limited ability to supplement their income, so ensuring that they can access adequate housing requires an investment in social housing. Don Fiddler of the Métis National Council highlighted the urgency of investments in social housing:

In the urban environment, there will need to be a hard look at subsidized housing. As I indicated, most of our citizens live in urban and semi-urban areas, and they are relying upon old age pension and in some cases small Canada Pension Plan benefits in order to provide them with income. They are tying to survive on the low income that those pensions represent. They have a median

Sharon Sholzberg-Gray, Canadian Healthcare Association, *Evidence*, December 10, 2007.

income of \$13,000 or \$14,000. Try living in an urban environment, with the high cost of housing, and well, it would be readily apparent that \$1,000 a month is essentially an average urban rent in not a very nice place; that is \$12,000 a year right there.

Evidence, May 14, 2007

Aboriginal organizations have stressed that the lack of quality, affordable housing is one of the greatest challenges to Inuit, Métis, and First Nations seniors. Some Inuit communities have 10-15 year waiting lists for social housing.³⁹ The housing situation in First Nations communities is addressed in greater depth in Chapter 10.

Access to affordable housing is one of the cornerstones of the World Health Organization's Age-Friendly Cities Guide, and a key component in allowing older Canadians to age in the place of their choice. The Committee welcomes the allocation of \$400 million over two years for the construction of social housing units for low-income seniors which was announced in the 2009 Budget. It emphasizes the need for continued funding in this area and for a national action plan, and recommends:

8. That the federal government, in consultation with the provincial and territorial ministers responsible for housing, increase the stock of affordable housing for seniors across the country, including supportive housing, by developing a long-term national affordable housing action plan.

2.2.1.3 Building codes

Housing should respond to needs throughout life. This can best be done at the initial design and building stage.

Under Canada's *Constitution Act*, building regulation is the responsibility of provincial and territorial governments. The *National Building Code* provides a model which can be adopted by the appropriate authority. Most provinces and territories adopt or adapt the model *National Building Code* and enforce its requirements. In a report on seniors in Ontario, the Ontario Human Rights Commission

³⁹ Okalik Eegeesiak, Inuit Tapiriit Kanatami, *Evidence*, May 14, 2007.

reported that "the standards for barrier-free design that are already contained in the *Building Code Act* are often not met by builders or enforced by inspectors." Consumers may not think about looking for accessibility features when they are buying housing, but the Committee has heard many stories about seniors who are confronted

with the difficult decision of moving out of their homes because they cannot be adapted to their reduced mobility. Judy Lynn Richards, Assistant Professor at the University of Prince Edward Island, shared an illustrative story with the Committee:

> I have done a fair bit of volunteering with seniors over the years, and there is nothing more disheartening than seeing someone who has been living in the same place for so long and is now at the point where they need a walker. They are still independent and can get around and cook and clean, et cetera, but they end up giving things up, such as their house, because they cannot get into the bathroom and they cannot afford \$5,000 worth of renovations to get the bathroom renovated. As soon as you leave the walker at bathroom door, there is the possibility of slipping and falling. What will you

Niagara is critically short of affordable supportive housing, particularly in the southern communities of Niagara. This shortage has been viewed by many informed observers as a root cause for the inordinately long wait list for long-term care homes in Niagara. Approximately 1,500 people typically are on the list for admission to long-term care homes in the Niagara region where there are 32 long-care homes.

Dominic Ventresca, Director of Senior Services, Regional Municipality of Niagara Community Services Department

grab onto in the middle of the bathroom in order to get to the other side? These are very practical considerations. There should be standard building codes so that people do not have to worry about whether or not at some point in their life they will have to put the walker aside to be able to enter their bathroom and then eventually have to give up their house because the bathroom is too slippery.

Evidence, June 11, 2007

Ontario Human Rights Commission, Time for Action: Advancing Human Rights for Older Ontarians, June 2001, p. 27.

Because accessible housing will continue to be an important component of allowing people to age in their homes, the Committee recommends:

9. That the federal, provincial and territorial ministers responsible for housing work to ensure that the standards for barrier-free design are consistently met by builders and enforced by inspectors.

2.2.2 Supportive Housing and Assisted Living

Although many seniors prefer to stay in their own homes, there is a transitional period where individuals confront mounting difficulties

Many seniors cannot afford upscale private "adult lifestyle" or retirement homes. Seniors' housing developments should not focus on "the gold in the grey" only.

> National Advisory Council on Aging

meeting their needs in their private housing. This group of seniors does not require the intensity of services in long-term care facilities but needs help with the activities of daily life. This can be provided in their homes through home support services and home care. It can also be provided in supportive housing. A wide range of services, both private and public, have arisen to either support individuals in their homes or to provide supportive housing options.

These options provide some services to support daily living - such as meals, housekeeping and social and recreational activities - while providing greater flexibility and less intensive care

than long-term care facilities. Supportive housing can be made available in a variety of building types and sizes. These range from small bungalows or cottages to homes shared by a group of eight to ten people to larger buildings that contain many dwelling units. Supportive housing can also be made available in various forms of tenure, such as rental, condominium and life leases.⁴¹

Luis Rodriguez, Senior Researcher, Canada Mortgage and Housing Corporation, *Evidence*, December 10, 2007.

As in other forms of housing, wealthier Canadians have a much broader range of options in supportive housing than low-income

seniors. The private sector is marketing a range of luxury accommodations to seniors, however there is a need to support the development of supportive housing options for low-income seniors. The Committee has heard that "the lack of affordable supportive housing contributes to many health care system inefficiencies and the unnecessary expenditure of hundreds of thousands of dollars to work around the system's backlog."⁴²

Residents in our village had to move to Medicine Hat which is 1 -½ hours away, so that not only do they have to adjust to leaving their home, they are having to adjust to living in a long term care facility with no family nearby.

The need to address standards in supportive housing is particularly important in light of the shortages in the supply of affordable supportive housing. Supportive housing and assisted living are not heavily regulated across

Anonymous response to Committee's questionnaire

the country because there is an assumption that consumers can exercise choice between providers, thus placing upward pressure on service standards. Consumers can only "vote with their feet", however, if there are other suitable and affordable supportive housing options to which they can turn. Ensuring that low-income seniors have choices in affordable supportive housing options, as recommended above, may place upward pressure on the quality of services provided in supportive housing facilities.

The Committee has received a number of suggestions from witnesses relating to how the federal government can share best practices on the regulation of supportive housing, and the role it can play in providing a single access point to all Canadians about the supportive housing options available across the country. Recognizing that the health of the supportive housing sector

The Committee urges the federal government to enter into discussion with the provincial-territorial forum of ministers responsible for housing to determine the most appropriate role it can play in coordinating best practices and information relating to supportive housing.

is key to providing a smooth continuum of services to seniors, and to

Dominic Ventresca, Regional Municipality of Niagara Community Services, *Evidence*, May 9, 2008.

Margaret Isabel Hall, University of British Columbia, Evidence, December 10, 2007.

reducing undue pressure on the long-term care sector, the Committee urges the federal government to enter into discussion with the provincial-territorial forum of ministers responsible for housing to determine the most appropriate role it can play in coordinating best practices and information relating to supportive housing.

The Committee urges the federal government to enter into discussion with the provincial-territorial forum of ministers responsible for housing to determine the most appropriate role it can play in coordinating best practices and information relating to supportive housing.

livina facilities Assisted are situated between supported housing options (which typically do not provide assistance with the activities of daily living), and long-term care facilities, where people have more extensive care requirements. Assisted living facilities are less regulated than long-term care facilities. The Committee has heard that these facilities are often marketed as

luxury accommodations, and that "some operators of these facilities have been looking for a frailer group of elderly residents to market their services."⁴⁴ The Committee takes seriously the call for vigilance to "ensure that assisted living facilities do not become entrenched as unregulated long-term care facilities with à la carte care"⁴⁵, and strongly urges the federal government to monitor this situation through ongoing dialogue with its provincial counterparts.

2.2.3 Long-term care

In 2005, there were 2,086 long-term care facilities for the aged in Canada, of which 1121 (54%) were privately owned, 447 (21%) were owned by not-for-profit organizations, and 420 (20%) were owned by governments. 46 Long-term care facilities are provided across

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Sharon Sholzberg-Gray, President and Chief Executive Officer, Canadian Healthcare Association, *Evidence*, December 10, 2007.

⁴⁵ Ihid

An additional 98 facilities are listed as "other". Statistics Canada notes that "All facilities in Quebec fall into this category as their ownership cannot be further defined." Source: Statistics Canada. Table 107-5501 - Residential care facilities, by ownership, principal characteristic of predominant group of residents and size of facility, Canada, provinces and territories, annual (number), CANSIM (database), Using E-STAT (distributor), https://estat.statcan.ca/cgi-win/cnsmcgi.exe?Lang=E&ESTATFile=EStat\English\CII 1 E.htm&Root Dir=ESTAT/.

Canada by municipalities, provincial or territorial governments, charities or private businesses.

The Committee has heard that there is a patchwork quilt of long-term care across this country with a variety of different charges applied for services and supplies depending on the province. There is not even common terminology for the sector - long-term care facilities are known throughout Canada as special care homes, nursing homes, continuing care centres, personal care homes, government manor homes, private manor homes, homes for the aged, and residential continuing care facilities.

With regard to improved care, we need to look at approaches to be adopted by home care, community services and long-term care facilities to preserve function and maintain a good quality of life for people with dementia, including high quality end-of-life care.

Scott Dudgeon, Alzheimer Society of Canada

2.2.3.1 Portability of Long-term Care Services

Long-term care centres are regulated at the provincial and territorial level, although the federal government has a direct role in providing assisted living or long term care services for certain groups - Aboriginal peoples through the First Nations and Inuit Home and Community Care Program; Correctional Service Canada's long-term care to federal inmates; and services provided to Veterans and former RCMP officers if they meet the criteria contained in each of their benefit programs.⁴⁷ The direct service role of the federal government in long-term care is explored in Chapter 10.

There are two groups of services defined under the *Canada Health Act*: insured health care services and extended health care services (which include long-term care). The *Canada Health Act* outlines five principles which provinces and territories must meet in order to receive health funding: public administration, comprehensiveness, universality, portability, and accessibility. These principles apply to the insured health care services but not extended health care services.⁴⁸ Dr. Hollander, who has appeared before the

Health Canada, Home and Continuing Care, on-line document at http://www.hc-sc.gc.ca/hcs-sss/home-domicile/index_e.html.

The two groups of services covered by the *Canada Health Act* are insured health care services and extended health care services. Insured health care services are

Committee, has written that "this is why, for example, it is possible to charge user fees in long term care facilities and why most continuing care services are not portable across provinces." The distinction between insured health care services and extended health care services may not be clear to Canadians. Witnesses have suggested that Canadians may not be aware that some of the services in long-term care facilities are not provided in the publicly funded health care system. As a result, many are unprepared for the costs of these services, or may not recognize that there may be waiting periods imposed when they try to access long-term care services in other provinces.

The Committee urges the provinces and territories to work on implementing reciprocal arrangements to eliminate the waiting period for long-term care services for residents from other provinces.

The lack of portability for long-term care services causes hardship for seniors and their families. Provinces and territories have different ways of calculating the subsidies they provide to seniors to pay for facility-based long-term care. As they move across the country, seniors may have to pay the full fee of the long-term care facility for an

extensive waiting period before being eligible for cost-sharing through their new province or territory of residence. The Committee has heard that some are required to pay the full fee in long-term care facilities for periods of as long as one year. This is an insurmountable barrier for some seniors and their families. The Committee urges the provinces and territories to work on implementing reciprocal arrangements to eliminate the waiting period for long-term care services for residents from other provinces.

Hollander, M.J. Substudy 1: Final Report of the Study on the Comparative Cost Analysis of Home Care and Residential Care Services. Victoria. National Evaluation of the Cost-Effectiveness of Home Care, 2001. p. 33.

medically necessary hospital services, physician services and surgical-dental services provided to insured persons. Extended health care services include certain aspects of long-term residential care (nursing home intermediate care and adult residential care services), and the health aspects of home care and ambulatory care services.

Sharon Sholzberg-Gray, President and Chief Executive Officer, Canadian Healthcare Association, *Evidence*, December 10, 2007.

2.2.3.2 Training of long-term care staff

The Committee has heard that long-term care facilities are increasingly called on to care for seniors who are older than they were

in the past, with much more complex health needs. In spite of this, there have been cutbacks in staffing in several jurisdictions. Sandra Hirst, President of the Canadian Association on Gerontology, told the Committee that:

Where we had registered nurses, for example, we are now using licensed practical nurses, LPNs, or registered psychiatric nurses. Where we had LPNs, we are now using nurse's aides, because of funding.

Evidence, December 11, 2006

Judith Wahl, Executive Director of the Advocacy Centre for the Elderly, told the Committee "We see an increase in persons with dementia in long-term care and we see the call for training, but the training does not get done." The Committee has heard the disconnect between the increasing complexity of care and cut-backs in staffing may be leaving seniors vulnerable. Sandra Hirst, President of the Canadian Association on Gerontology, explained:

Taking the time to give a senior who needs care, a bath, preparing a meal, feeding the individual and ensuring a safe and sanitary environment in the home does not necessarily have to be done by a health professional. However, for people who are too frail to shop, cook or take baths on their own due to their medical conditions, this type of personal support allows them to maintain their independence for as long as possible. It may actually save the health care system money by avoiding repeated hospital admissions and premature entry into long-term care facilities.

Marcus J. Hollander, Hollander Analytical Services Ltd.

We are asked to provide care to complex older adults who have a variety of needs. Older adults entering long-term care rarely present with one health issue. They have multiple concerns ... Perhaps the most vulnerable of our senior population is cared for primarily with uneducated staff at their bedside. That is deplorable.

Evidence, December 11, 2006

Judith A. Wahl, Executive Director, Advocacy Centre for the Elderly, *Evidence*, May 28, 2007.

The Committee urges the federal government to work closely with its provincial and territorial counterparts to ensure that the levels of care in long-term care facilities across the country are appropriate.

The Committee is very concerned about this situation and urges the federal government to work closely with its provincial and territorial counterparts review and adjust staffing to competencies in long-term care facilities, to ensure that the levels of care in long-term care facilities across the country are appropriate.

2.2.3.3 Culturally-appropriate long-term care services

Several witnesses emphasized the importance of developing culturally appropriate long-term care services. This is the case in Ste-Anne, Manitoba where the Committee heard about the importance of receiving care in one's first language. It is the case in First Nations communities, even though a small minority of First Nations people in Canada have the opportunity to receive long-term care in their communities. It is also the case for multicultural communities, even among those who may have been in Canada for most of their lives.

A growing number of seniors in Canada were born outside of Canada. These seniors will require assisted living or long term care facilities as they age. Providing culturally sensitive services that meet the unique needs of immigrant seniors will become increasingly important to ensure that visible minority seniors are comfortable in facilities. Gloria Gutman, Professor of Gerontology at Simon Fraser University, told the Committee:

We recognize that when people have developed dementia, if they are from another country and English is not their first language, they many lose their English but still be able to communicate in their foreign language. One of the advantages of cultural groups having developed their own care facilities and having maintained their culture is so that people can function in that kind of setting.

Evidence, March 19, 2007

Jessica Luh, "Ethnicity, Older Adults, and Long-Term Care," *Innovations: Enhancing Ability in Dementia Care*, Vol. 2, No. 4, (Fall 2003), p. 1-2.

The Committee heard evidence about the difficulty that some care institutions can have in adapting to the different needs of immigrant seniors. A report by the Ontario Human Rights Commission noted that "the provision of food, social and recreational activities in such (long-term care) institutions may not respond to the particular cultural and religious needs of some older persons."

The Committee urges the federal government take a proactive role in communicating information and best practices about adapting long-term-care facilities to address the needs of a multicultural society.

The Ontario Human Rights Commission recommended "that health care and other service providers should seek to find ways to deliver services to a range of ethnic, cultural, racial, linguistic and religious groups."⁵³ The Committee urges the federal government take a proactive role in communicating information and best practices about adapting long-term-care facilities to address the needs of a multicultural society.

2.2.4 Home Care and Home Support

According to the Royal Canadian Legion, "the biggest challenge facing Canadians over age 75 is bridging the gap between independent residential living and moving to a care facility."⁵⁴ Home support and home care can help bridge that gap.

A wide range of services can fall under home care programs, including professional services such as nursing, occupational therapy, and social work; personal care services to assist in the activities of daily living, such as bathing, toileting, transferring, and grooming; and home making and home support services such as cleaning, doing laundry and meal preparation.⁵⁵ It is often a combination of these services that allow individuals to postpone or avoid institutional care.

Royal Canadian Legion, Review and Determination of Housing Issues for Veterans and Seniors, p. vi.

Ontario Human Rights Commission. Time for Action: Advancing Human Rights for Older Ontarians, June 2001, p. 31.

Royal Canadian Legion, Review and Determination of Housing Issues for Veterans and Seniors.

In the last century, the advances made in medical care and technology have made living easier but dying harder, and the reality of being elderly is that it is the elderly who die mostly. The system we have now needs to change in order to make end-of-life care a quality time for these patients.

Dr. Lawrence Librach, Canadian Hospice Palliative Care Much of the care and support seniors receive at home is provided by family members and friends in an informal way. The Canadian Home Care Association has noted that the informal or family caregiver is the backbone of the home care system in Canada. The Canadian Institute for Health Information reports that "for many people, the informal support provided through family, friends and neighbours makes the difference between living in the community and requiring an alternate level of care, such as a residential care facility or hospital." The issues and options relating to informal home care are provided in Chapter 6.

There are times when the support provided by family and friends needs to be supplemented with formal supports to help

people with acute and chronic care needs stay in their homes. There are also times when family and friends are not able to provide care or support. The ability of public home care services to meet these needs differs dramatically across the country in terms of what is offered and how services are funded. In too many cases, the levels of care provided are not sufficient to support people in their own homes, as Sue VanderBent of the Canadian Home Care Association outlined in her brief to the Committee:

Growing numbers of community-dwelling seniors are "at risk" for loss of independence because they need more help than is currently available in the health care system to age at home. A clearly identifiable trigger point for imminent loss of independence occurs when families decide ... to activate the search for placement for the senior to a retirement or long term care facility. This activity is often initiated for individuals at the fringe – those needing a little more support than offered within the community system and not really requiring the full scope of services offered in the facility. It is at this point where

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⁵⁶ CIHI, Analysis in Brief, "The Yukon: Pioneers in Home Care Information", October 2007.

A. Côté and G. Fox, *The Future of Homecare in Canada: Roundtable Outcomes and Recommendations for the Future*, March 2007.

enhanced and focussed services delivered in the home could make a major difference in the quality of life for both the senior and their families.

Access to home and community services is limited in Canada. The Victorian Order of Nurses, in its brief, noted that:

Access is impeded for a variety of reasons – for example, geographic location, language, and culture, but one of the primary barriers to accessing home and community care is related to cost. Only 50 percent of home care patients in Canada receive publicly funded care.⁵⁸

Despite the growing number of seniors, the Committee has heard that some provinces have experienced a decrease in the home support and home services over the past decade. In his brief to the Committee Chris Boldt of the B.C. Retired Teachers' Association noted that the decline in home support and home services in British Columbia over the last 10-15 years has placed increased pressure on family caregivers and made it increasingly difficult for seniors to stay in their homes.

Home care and home support is what Canadians want when their health makes it difficult for them to manage the activities of daily life. Nothing makes that more clear than a pilot project conducted by Veterans Affairs Canada in 1999, as outlined below.

VON Canada, Submission to the Special Committee on Aging, December 17, 2007. p. 4.

The Overseas Service Veteran At Home Pilot

Faced with a shortage of beds in its facilities, the Department of Veterans Affairs Canada offered the veterans on its waiting list for long-term care placement the range of supports available under its Veterans Independence Program, which includes a wide range of home support services. When the pilot project was assessed in 2002, "90 percent of the veterans contacted chose to remain at home with Veterans Affairs Canada interventions rather than accept long-term care facility placement." Although they had had their names on a waiting list for a long-term care facility, the vast majority of participants preferred to remain at home. ⁵⁹

In its Second Interim Report, this Committee proposed the option of introducing a National Home Care Program. Reaction to this proposal was mixed. Witnesses strongly supported an increase in home care and home support services; however, they had important caveats about the introduction of a national program. pointed out that the 2003 First Ministers' Accord on Health Care Renewal, which had recognized short-term home care as a part of the acute care system, had had the unexpected negative consequence of reducing the availability of longer-term care. Many seniors who require home care have chronic health conditions which require longer term home care. Witnesses emphasized the importance of ensuring that the range of supports to seniors be considered in an integrated fashion rather than in an ad hoc way. Summarizing the conclusions of the National Evaluation of the Cost-Effectiveness of Home Care, of which he had been part, Marcus Hollander of Hollander Analytical Services told the Committee that:

...home care, in order to more readily make the types of substitutions required to achieve greater efficiencies, needs to be part of a broader, integrated system of home and residential care, often referred to as continuing care. By having administrative and fiscal control over such a large, integrated system of care, senior executives and policy- makers can take steps to ensure that appropriate and cost-effective substitution of home care services for acute care and residential care can, in fact, take place.

⁵⁹ Pedlar, David and John Walker. "Brief Report: the Overseas Service Veteran at Home Pilot: How Choice of Care May Affect Use of Nursing Home Beds and Waiting Lists," Canadian Journal on Aging 23 (4): p.368.

Simply enhancing expenditures on home care per se may have a limited effect unless steps are taken to ensure that appropriate substitutions of home care services for acute and/or residential care services can be made.

Evidence, December 10, 2007

Home care and home support are an essential part of providing integrated care to Canadians. The Committee emphasizes the important role the federal government can play in working with the provinces and territories to address the needs of people in need of home care and people providing that care.

The Committee emphasizes the important role the federal government can play in working with the provinces and territories to address the needs of people in need of home care and people providing that care.

The Committee recommends:

10. That, as home care is a key component of a national integrated care initiative, a Seniors Independence Program, modelled on the Veterans Independence Program administered by Veterans Affairs Canada, form part of the home care/home support component.

The Committee also recognizes the important role that home care and home support workers can play in maintaining the quality of life of seniors. For many isolated seniors, home support workers can play a key role in providing information on health promotion and eligibility for programs. However, this role does not appear to be systematically integrated into the work of home support workers, in part due to the low status given to the important work they do. 60

Home Support Workers and Health Promotion

In her work, Vicky Scott of the University of Victoria trained home support workers to conduct falls risk assessments when they are in people's homes. Her work resulted in a remarkable 50 percent reduction in falls over an 18-month period compared to homes where the workers did not have that training.

⁶⁰ Anne Martin-Matthews, Scientific Director, Institute of Aging, Canadian Institutes of Health Research, *Evidence*, April 7, 2008.

The Committee heard that non-professional or paraprofessional workers provide most of the paid home care services in the country. They are often among the lowest paid group in the health care field, work with the fewest benefits, often pay for their own training and, in some provinces, pay their own travel expenses. It has been suggested that the lack of a national human resources strategy and training standards for this sector has a significant impact on the quality of care from one region to another. This issue is addressed in chapter 8 of this report.

2.2.5 Palliative Care

It is important to allow people to age in the place of their choice. It is also important to provide the right services to allow people to die in the place of their choice. Palliative care services are a key part of providing the care that is needed, at the time and place that it is needed. The Committee has heard that effective palliative care can provide services in people's homes, nursing homes, and residential care facilities. The Committee was disturbed to hear while most Canadians with life-threatening illnesses would prefer to die at home, 75 percent continue to die in hospitals and long-term care facilities. In addition, Dr. Lawrence Librach, Vice-President of the Canadian Hospice Palliative Care Association, told the Committee that:

The elderly, if they are admitted to long-term care facilities, generally will not receive good quality end-of-life care. Patients who are admitted to long-term care facilities are there to die; they are just giant palliative units.

Evidence, June 18, 2007

There are many things that can be done to allow Canadians to die in the place of their choice. The Committee has heard that in some palliative care programs in Canada, 70 percent of patients can die at home.

Allowing seniors to die in the place of their choice will require close collaboration between palliative care professionals, seniors, their

Jane Barratt, International Federation on Ageing, *Evidence*, December 11, 2006.

Dr. Lawrence Librach, Vice-President, Canadian Hospice Palliative Care Association, *Evidence*, June 18, 2007.

families, and other health and social service professionals. Economist Marc Lee has suggested that expensive end-of-life treatments are not always what is desired by dying seniors, and such interventions do not necessarily improve the quality of life. He notes that "in contrast, palliative care options have been suggested that assist people to die with dignity at home or in a home-like setting rather than in hospital."⁶³

Just as proper geriatric assessments can help determine the optimal basket of services to provide a high quality of life at home or in residential care, so too a well-defined palliative assessment processes can help define a good management plan for dying. Nadine Henningsen, Executive Director of the Canadian Home Care Association, highlighted the ongoing training needs in the area of palliative care:

One of the areas where we certainly see opportunity, and there are some models currently happening, is training groups together — training the home support worker, the palliative care physician, the family caregiver and the nurse all together, training them not necessarily on the hands-on duties of how to provide good palliative care but training them in how to work together, how to ensure that they do not duplicate services, providing opportunities for communication so you start to build a strong partnership with all the health human resources.

Evidence, June 18, 2007

The Committee endorses the recommendation of Sharon Baxter of the Canadian Hospice Palliative Care Association that "a crucial leadership role exists for the federal government to guide and oversee activities so that quality end-of-life care services are integrated into the health care system, are coordinated with other health systems, are comprehensive in nature and are an effective use of health care dollars" and recommends:

⁶³ Marc Lee, Is BC's health Care system sustainable? A Closer look at the Costs of Aging and technology, Canadian Centre for Policy Alternatives, November 2006, p. 21.

11. That the federal government fund a national provinces, territories partnership with community organizations to provide the leadership and vision, standards, best practices, awareness and support for capacity building necessary to ensure the provision of integrated quality end-of-life care for all Canadians.

The Committee heard that while the work completed in the Canadian Strategy on Palliative and End-of-Life Care moved the issue of palliative care forward, there is still much need for the continued support and leadership which the federal government is wellpositioned to provide. In order to continue to lay the ground-work which will allow Canadians to have a greater quality of life at the end of their lives, the Committee urges the federal government to provide leadership and coordination on the issue of palliative and end-of-life care.

In the 2004 10-Year Plan to Strengthen Health Care, federal, provincial and territorial First Ministers committed to provide first dollar coverage for certain home care services, including "case management, nursing, palliative-specific pharmaceuticals and personal

The Committee urges the federal government to provide leadership and coordination on the issue of palliative and end-of-life care.

care at the end of life."64 To support provincial and territorial government efforts to fulfill their commitment, the Canadian Hospice Palliative Care Association in partnership with Canadian Home Care Association has defined the "gold standard" for each of

the four home care services to be funded by government: case management, nursing, palliative-specific pharmaceuticals and personal care at the end of life. 65 The federal government has the responsibility, as the fifth largest health provider to Canadians, to meet the "gold standard" for the population groups under its direct service jurisdiction. As a result, the Committee recommends:

Canadian Hospice Palliative Care Association, The Pan-Canadian Gold Standards in Palliative Home Care: Toward Equitable Access to High Quality Hospice Palliative and End-of-Life Care at Home.

Canadian Hospice Palliative Care Association, The Pan-Canadian Gold Standards in Palliative Home Care: Toward Equitable Access to High Quality Hospice Palliative and End-of-Life Care at Home.

12. That the federal government apply the gold standard in palliative home care developed by the Canadian Hospice Palliative Care Association and the Canadian Home Care Association to veterans, First Nations and Inuit, and federal inmates.

The Canadian Institutes of Health Research (CIHR) has provided funding for research on palliative care since 2004; but that funding is due to expire in 2009. The Committee has heard that there is still a need for research on effective pain and symptom management, psychosocial aspects of hospice palliative care, and effective methods of delivering hospice palliative care services and programs within the health care system. Canada has begun to build capacity in this area, but more needs to be done. In order to build on existing research and to translate the current research on hospice palliative care in ways which are useful for the public and practitioners, the Committee recommends:

13. That Canadian Institutes of Health Research funding for palliative care be renewed beyond 2009.

Chapter 3: Comparable Access to Services Across the Country

3.1 Seniors and Health Care Costs

Population pressures do not endanger the health care system; it is not the major driver of the increases in costs that we have observed.

Byron Spencer, Professor of Economics, McMaster University, *Evidence*, May 5, 2008

A pervasive myth needs to be put to rest. Our aging population will not be responsible for the collapse of health care as we know it.

Although health care costs have increased significantly in recent years, these increases have primarily been due to an expansion of health care services, population growth and health-care-specific inflation. In comparison, the impact of population aging is a relatively small factor driving health care costs. Marc Lee, Senior Economist for the Canadian Centre for Policy Alternatives, told the Committee:

We can provide the same level of services that we have today into the future with an aging population. I believe that is a very high level of health care services. To the extent that we want more, if we want more and better health care services, then we do indeed have to pay for that and pay a larger share of our collective income in doing so. However, we have to ensure we are not confusing expansion of the health care system with what is required minimally to maintain it.

Marc Lee, Evidence, May 5, 2008

Internationally, there is no relationship between the proportion of seniors in a country and health care spending, nor is there a link between the increase in the proportion of seniors over the last 25

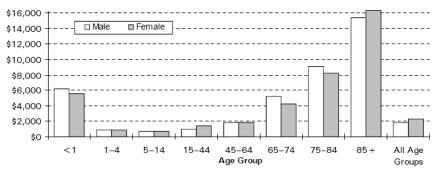
Marc Lee, Senior Economist, Canadian Centre for Policy Alternatives, Evidence, May 5, 2008.

years and increases in health care spending. Within Canada, per capita spending by provincial governments on health is not associated with the proportion of seniors in that province's population.⁶⁷

This is not to say that population aging will not have any impact on health care spending. It does lead to increased costs. But those costs are manageable, and each province makes its own choices about what care is available and how it is organized, within the framework of the Canada Health Act.

The pressure on health care costs created by population aging results from the fact that health care use is typically most intensive in the first and last years of life, as illustrated by Figure 3.1 below.

Figure 3.1: Provincial and Territorial Government Health Expenditure per Capita, by Age Group and Sex, Canada, Constant 1997 Dollars, 2002.



Source: Canadian Institute for Health Information, *Provincial and Territorial Government Health Expenditure by Age Group, Sex, and Major Category: Recent and Future Growth Rates*, May 2005.

Although health care costs have increased at similar levels across all age groups over the last decade, the larger basis of spending in older age categories means that proportional increases translate into much larger real costs.

In addition to health care costs, it is expected that population aging will also put increased pressure on home care, continuing care and other complementary services.⁶⁸ This reinforces the importance of moving toward greater integration of services in order to make the most effective trade-offs, improve care, and keep expenses down, as discussed in Chapter 2.

68 Marc Lee, *Evidence*, May 5, 2008.

Jean-Marie Berthelot, Vice-President, Programs, Canadian Institute for Health Information, *Evidence*, December 3, 2007.

3.2 Health Promotion Efforts Can Help Reduce Health Care Costs

Health promotion is defined as "the process of enabling people to increase control over, and to improve, their health."⁶⁹ Studies show that health promotion and disease prevention strategies can help people age well, help reduce the prevalence of chronic conditions, and thus lower costs to the health care system. Many witnesses emphasized the importance of promoting health throughout the lifecourse. Victor Marshall, Professor of Sociology at the Institute on Aging of the University of North Carolina, told the Committee that "experts in health promotion and disease prevention stress it is never too late and also never too early to initiative health promotion strategies that will produce positive effects."⁷⁰ The Committee heard many examples of innovative programs to help older Canadians improve their level of physical activity⁷¹ and nutrition.

Improving nutrition in long-term care facilities

Eating well is an important part of staying healthy. Dr. Hélène Payette, Professor in the Faculty of Medicine and Health Sciences at the University of Sherbrooke, told the Committee that research has been conducted in a number of long-term health care facilities in Canada and Europe where small health care units were outfitted with their own kitchens and dining rooms. All of those studies have shown an improvement in residents' nutritional status, vitality and sociability. The Committee witnessed this in action in Halifax at the Camp Hill Veteran's Memorial Building, where a food-warming station filled the floor with the smell of the prepared breakfast, attracting residents to the eating area. The committee witnessed the prepared breakfast attracting residents to the eating area.

Gudrun Langolf, Director of the Council of Senior Citizens' Organizations of British Columbia, reminded the Committee that many of the conditions citizens deal with later in life originate from conditions in their early years, and that "the band-aid or repair service

⁶⁹ World Health Organization, Ottawa Charter for Health Promotion, 1986.

Victor Marshall, Professor of Sociology, Institute on Aging, University of North Carolina, *Evidence*, February 19, 2007.

⁷¹ See Chapter 4 of this report.

⁷² Dr. Hélène Payette, Professor in the Faculty of Medicine and Health Sciences at the University of Sherbrooke, *Evidence*, May 16, 2008.

mode of dealing with these issues has negative consequences for our society."⁷³ Robert Dobie, Acting Chairof the National Advisory Council on Aging, encouraged the Committee to consider the importance of health promotion:

I cannot overstress that an effective health system must place as much emphasis on health promotion as it does on health care. The causes of some serious conditions associated with aging will elude us, as will their prevention and treatment methods. However, many ill effects of chronic conditions associated with aging are avoidable. Health promotion, including for the very old, can produce beneficial results. The prevention of falls, as well as changes in lifestyle, particularly with respect to physical activity and nutrition, must be given priority in promotion and prevention programs for the aging population.

Evidence, November 27, 2006

The Committee recognizes the importance of a comprehensive health promotion strategy, recognizing that this will save money in the long run by increasing the years of living in good health and delaying the onset of health problems.

Delaying the onset of Alzheimers

Data from the United States suggests that if we could effect a five-year delay in the onset of Alzheimer's disease, we would cut its prevalence in the population by 50 percent, and we are attempting now, with the Alzheimer Society of Canada, to generate equivalent data for the Canadian situation. The Institute of Aging has recently launched an initiative called RAPID, Research to Action Program in Dementia, where we are working with practitioners on issues of delay of onset.

Anne Martin-Matthews, Scientific Director, Institute of Aging, Canadian Institutes of Health Research

Gudrun Langolf, Director, Council of Senior Citizens' Organizations of British Columbia, *Evidence*, June 5, 2008.

The federal government plays a role with respect to health

promotion and disease prevention by developing, implementing and assessing programs and policies whose specific objective is to encourage Canadians to live a healthier lifestyle. The work of the Public Health Agency of Canada, for example, is health promotion, focused on prevention of chronic diseases such as diabetes and cardiovascular diseases, and injury prevention. By increasing health promotion efforts, the federal government could play a role in reducing overall health care expenditures. As a result, the Committee reiterates the recommendation made by the Standing Senate Committee on Social Affairs, Science and Technology in its study on the Health of Canadians⁷⁴ that

The Committee reiterates the recommendation made by the Standing Senate Committee on Social Affairs, Science and Technology in its study on the Health of Canadians that the federal government ensure strong leadership and provide additional funding to sustain, better coordinate and integrate the public health infrastructure in Canada as well as relevant health promotion efforts.

the federal government ensure strong leadership and provide additional funding to sustain, better coordinate and integrate the public health infrastructure in Canada as well as relevant health promotion efforts.

3.3 Demographic Projections for Provinces and Territories

Not all regions of the country are aging equally. Population migration as well as differing fertility rates are amplifying regional disparities. Provinces which already have older populations are aging more quickly, especially the five easternmost provinces.

The Standing Senate Committee on Social Affairs, Science and Technology The Health of Canadians – The Federal Role. Final Report, Volume Six: Recommendations for Reform, 2002.

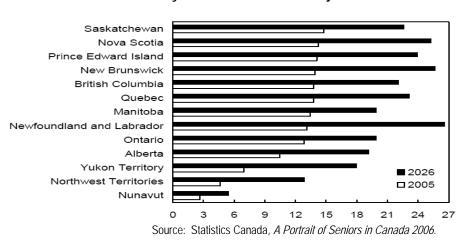


Figure 3.2: Percentage of Population Aged 65 or Over, by Province, 2005 and Projection for 2026

As Figure 3.2 suggests, differences in population age structure across the provinces and territories are expected to widen in the future.

3.4 A Supplementary Program to Compensate for Uneven Aging Across the Provinces and Territories

Because the costs of providing health care to seniors is higher than for other age groups, provinces with higher proportions of seniors will face greater increases in costs than others. The Canada Health Transfer's per-capita funding formula does not take these differential costs into consideration, and may eventually result in a widening gap in the basket of services offered by provincial and territorial governments, as noted in the Government of Nova Scotia's brief to the Committee:

Nova Scotia is concerned that the current federal approach -- moving to equal per capita funding for federal transfers -- will create new funding sustainability problems for jurisdictions such as Nova Scotia.⁷⁵

Government of Nova Scotia, Report to Senate Committee on Aging – Nova Scotia's Perspective, June 13, 2008.

We believe it is essential to ensure that Canadians across the country, be they young or old, have fair access to services, and that jurisdictions with older populations not be penalized because of their demographic status.

The Committee's second interim report on Issues and Options considered a number of options for addressing this imbalance. In our hearings, witnesses were clear that attempting to incorporate age-based considerations into the existing equalization and Canada Health Transfer formulas would be contentious and challenging, given the broad scope of those programs.

The Committee believes a distinct transfer payment to the provinces is the simplest way to offset the differential costs associated with population aging.

The most straightforward way to offset the costs associated with a population that is aging more rapidly is through a distinct transfer payment to the provinces for that purpose, a

payment to the provinces for that purpose, as described by Joe Ruggeri, Professor of Economics at the University of New Brunswick:

Having a separate supplement specifically directed at the issue has great advantages in terms of transparency, accountability and targeting. It also would be a transitory transfer introduced to address a transitory issue. It can be designed to be very sensitive to the changes in the magnitude of the aging issue.

Evidence, May 5, 2008

The Committee therefore recommends:

14. That the federal government create a supplementary transfer program to assist provinces and territories which have an older population in meeting the increased health care needs of their seniors.

3.5 Comparable Access to Medications: A National Formulary

While virtually all seniors are covered by some type of prescription drug insurance, either public or private, the extent of this coverage varies significantly from province to province, leaving many seniors vulnerable to financial hardship.

Robert Dobie, Acting Chair, National Advisory Council on Aging, *Evidence*, November 27, 2006

Pharmaceuticals, particularly prescription medications, are seen as one of the three essential pillars of health care along with services provided by physicians and hospitals. Seniors are particularly in need of medications to prevent complications, treat chronic disease, control pain, and to reduce or control symptoms during and at the end-of-life. However, unlike physician and hospital services that are generally covered as medically necessary services, prescription drugs used outside of hospitals are paid out-of-pocket unless covered by a public or private drug insurance plan.

Provincial and territorial governmental drug benefit plans are the primary source of drug insurance for Canadian seniors. Each government has traditionally had its own prescriptions drug benefit plan and individual formulary listing for drugs approved for coverage under the plan. This means that currently there are 10 provincial, 3 territorial and 6 federal formularies, potentially 19 lists of drugs that could be approved as a benefit for eligible seniors. As well, while each provincial and territorial plan has introduced premiums, co-payments or deductibles to be charged to the plans' users, the federal plans generally cover the full costs of the medications approved as benefits for seniors.

The result is a patchwork of medication benefits available to seniors across the country. For example, medications approved by Health Canada to treat Alzheimer's disease may not be listed on all provincial formularies, preventing access by seniors who cannot afford the high cost of purchasing the medication. The costs, combined with disparate benefits available through provincial formularies, have health consequences. According to Donald Juzwishin of the Health Council of

Canada, the direct out-of-pocket cost leads some seniors to reduce or stop their prescribed treatments:

In our survey, we found that 10 percent of Canadians with chronic diseases reported that they do not fill a prescription or they skipped amedication due to the associated costs.

Evidence, April 7, 2008

Prescription drugs are an essential part of integrated care for seniors. Despite efforts by federal, provincial and territorial governments to provide appropriate access to medications outside hospital settings, there is inconsistency and inequity in prescription drug coverage for Canadians across the country. A common national formulary is generally viewed as a vital first step toward addressing jurisdictional discrepancies. This, along with the idea of a national publicly-insured prescription drug program, received the support of a range of witnesses appearing before the Committee.⁷⁶

The Committee acknowledges however that a common national formulary and one uniform drug plan for the whole country will require significant jurisdictional collaboration. The Committee notes that the move to a national formulary was supported in 2002 by both the Commission on the Future of Health Care in Canada and the Standing Senate Committee on Social Affairs, Science and Technology. The establishment in 2003 of the Common Drug Review process with participation by all jurisdictions except Quebec is viewed as a significant step toward its development. In addition, the Committee acknowledges the further cross-jurisdictional support as part of the 10-year Plan to Strengthen Health Care when First Ministers established a ministerial task force to develop and implement a National Pharmaceuticals Strategy.

The benefits of a national formulary are particularly significant for seniors. In addition to reducing inequities for seniors across all government plans, it can assist in promoting optimal use of medications as well as achieving administrative efficiencies. It is interesting to note that the cost of drugs used to be the third highest

For example, Hon. Michael Baker, Minister of Finance, Nova Scotia, Christine Mounsteven, Canadian Pensioners Concerned Incorporated, Marc Lee, Canadian Centre for Policy Alternatives, etc.

overall cost after hospitals and physicians; however, it is now the second highest cost after hospitals. Among federal drug plans, there is an opportunity to lead through the Federal Health Care Partnership that has already negotiated and coordinated federal government purchasing related to pharmaceuticals on behalf of certain departments and agencies representing specific eligible federal clients. Among all jurisdictions (federal, provincial, and territorial), comparisons of the current formulary drug lists can assess inconsistencies in coverage, identify ways to reduce inequities, and facilitate the development of a common national formulary.

One place to begin the establishment of a common national formulary is with the development of a list of drugs utilized by seniors across the country. This list can then be implemented as a national formulary for seniors.

The Committee therefore recommends:

15. That the federal government establish a specific time-limited fund to enable provincial, territorial and federal governmental drug benefit plans to develop a common list of drugs used by seniors; That this list form the basis of a common national formulary to be implemented by all jurisdictions as a benefit list for all Canadian seniors; and That this initial focus on seniors form the basis for a national pharmacare program.

Chapter 4: Active Aging in Age-Friendly Cities and Rural Communities

Aging in place of choice requires communities which are adaptable to the evolving needs of families and individuals. Across the country, there are innovative programs which are offered to seniors, often by their peers. These include university programs, computer classes, wood-working workshops, social clubs, and physical fitness programs. Some seniors confront barriers in accessing these programs for a number of reasons - the physical environment of communities may not be conducive to getting around easily or transportation may be too expensive or complicated. This calls for attention to the principles of universal design and the implementation of age-friendly community guidelines.

4.1 Active Aging

Older adults make many valuable contributions to society through knowledge accumulated over a lifetime of experience. At the same time society needs contributions from skilled workers and volunteers to provide the services and goods needed by a growing population and diminishing labour force.⁷⁷

Canada's National Framework on Aging, developed ten years ago to guide federal and provincial action on aging, outlined a vision that:

Canada, a society for all ages, promotes the well-being and contributions of older people in all aspects of life, promotes the well-being of seniors, recognizes their valuable contributions and reflects the goals of elimination of ageism in all sectors.

Many seniors continue to be active members of society through paid employment, volunteer work, educational opportunities, social

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Committee of Officials for Federal/Provincial/Territorial Ministers Responsible for Seniors, *Planning for Canada's Aging Population: A Framework*, 2005.

and intergenerational interaction, and in physical activity. The Committee has heard that opportunities to remain physically and mentally active are instrumental to the well-being of senior Canadians. Accelerated aging is the direct result of inactivity. Despite this, the evidence suggests that seniors may not recognize the importance of remaining active. Monika Queisser of the Organization for Economic Co-operation and Development testified that:

People tend to have lots of ideas before they retire of what they will do in retirement, such as charity and association work. Yet, when you look at actual time use ... you see that after people retire there is an incredible increase in passive time use, meaning that people sleep more and watch more television.

Evidence, May 7, 2007

The challenge for us is to spread the word that a healthy active lifestyle is the best means towards ensuring a longer, happier, healthy life as we age.

Active Living Coalition for Older Adults

Promoting active aging includes measures to ensure that everyone has opportunities to live an engaged and active life so that these lifestyle habits follow them into the senior years. It also requires a close look at the barriers which prevent some seniors from continuing to be actively engaged.

Recognizing that promoting active aging requires collaboration between individuals, the voluntary sector, the private sector, and the various levels of government.

4.1.1 Social and Intergenerational Interaction

Social interaction is important to mental and physical health. In its brief to the Committee, the Canadian Coalition for Seniors' Mental Health noted that:

Social support networks are particularly important for seniors as social isolation is known to be linked to depression and loss of autonomy. Community or institutional based programs that provide social support to seniors help to ensure maintenance of mental health.

Evidence, May 28, 2007

The Alzheimer Society reports that "social interaction appears to have a protective effect against Alzheimer's disease"⁷⁸ and recommends that seniors participate in social events with family and friends, stay active in the workforce or volunteer, join a club, hobby group, or take a class.

The organizations which provide social activities for seniors are at the forefront of services to seniors. As Judith Cameron of the Fairfield Activity Centre in Victoria told the Committee:

We are the frontline workers. We see our members on good days and bad days. We see them before they get to assisted living and land in hospital. We make referrals and we advocate for health care services, doctor referrals, home care, housing, and mental health.

Evidence, May 28, 2007

These organizations play an important role in relaying information to seniors and ensuring that they access the services available to them and need to be adequately supported. Many of the witnesses who addressed the Committee expressed concern for isolated seniors. Unlike those who participate in the activities and programs in their communities, isolated seniors may not hear about resources which could be available to support them, may not access information on issues such as abuse which could help them protect themselves, and may not come into contact with advocates who could make them aware of their entitlements.

The issue of social isolation came up at all the Roundtables on Seniors' Well-Being held by the National Seniors Council between February and May 2008. Seniors at those roundtables indicated that low income and a lack of transportation may place seniors at risk of social isolation.⁷⁹

Some groups of seniors are more likely to experience social exclusion, including the oldest old, women, seniors with less education,

National Seniors Council, Written Submission to the Special Senate Committee on Aging, June 2008.

Alzheimer Society, Heads up for Healthier Brains: What Everyone Should Know About Brain Health and Alzheimer's Disease.

those dwelling in urban areas, those not Canadian born, those not married and seniors whose health affects their activity level.⁸⁰

Research has demonstrated that urban seniors are much more likely to experience social exclusion, possibly because "rural seniors may benefit from more neighbourly and peer support in terms of transportation to and from family events and community activities because of an increased likelihood that people know one another."81 This calls for attention to age-friendly cities and rural communities.

Immigrant seniors are particularly at risk of social exclusion, although the Canadian Ethnocultural Council has urged the Committee to take into consideration the "richness of the social interactions, informal volunteering, self-help supports, associations, economic contributions and additions to the richness of Canadian society that ethnocultural seniors make". ⁸² Upcoming cohorts of seniors are likely to be even more culturally diverse than the current group of seniors. The Committee recommends:

16. That the federal government adequately support research on the social network needs of seniors, and that it support organizations which provide social activities for seniors, especially those which provide culturally relevant events and activities for seniors born outside of Canada.

4.1.2 Physical Activity

There are two good times to start exercising: one is when you are young and the other is today.

Elaine Gallagher, Director, Centre on Aging, University of Victoria, *Evidence*, April 28, 2008

Efforts need to be made to ensure that adults recognize the benefits of staying active into their senior years, and to provide the

Social Isolation Working Group, F/P/T Committee of Officials (Seniors), A Profile of Social Isolation in Canada- Phase II, November 2007.

Social Isolation Working Group, F/P/T Committee of Officials (Seniors), *A Profile of Social Isolation in Canada- Phase II*, November 2007, p. 10.

⁸² Anna Chiappa, Canadian Ethnocultural Council, *Evidence*, May 28, 2007.

range of services which will meet the needs of a physically active older population.

Staying physically active is key to remaining in good health. The good news is that it is never too late to start - adopting a healthy lifestyle in middle age, and later, can dramatically improve one's health and life chances, and the effects can be seen quickly.⁸³

Fitness is critical to preventing or delaying the onset of chronic diseases of aging, and in reducing the period of disability and dependent living, as Donald Paterson, Professor, School of Kinesiology, Faculty of Health Sciences, University of Western Ontario told the Committee:

The research shows a 50 percent reduction in the risk of going into long-term care in those who are fit, just moderately fit... That is because many people go into long-term care not because of cognitive dysfunction but rather because they cannot walk anymore.

Evidence, April 28, 2008

Physical activity can also minimize the effects of chronic conditions. Dianne Austin, National Executive Director of the Active Living Coalition for Older Adults, told the Committee:

Many people do not realize that the benefits of participating in physical activity will often decrease the pain they are in from osteoporosis or arthritis. Quite often, people assume they should not be moving; in fact, the opposite is true. The more they participate in exercise — especially strengthening exercises — the better they can reverse the complications of osteoporosis. However, for the most part, people do not realize that. The research has been done but not communicated to the general public.

Evidence, May 7, 2007

Australia, Prime Minister's Science, Engineering and Innovation Council, Promoting Healthy Ageing in Australia, 2003, p. 76.

It is important to find ways to support the delivery of exercise programs to community seniors. There is also the need to train leaders, instructors and educators.

Dr. Donald Paterson, School of Kinesiology, Faculty of Health Sciences, University of Western Ontario Sedentary living is a big problem among all Canadians, including older adult Canadians. Only a minority are adequately physically active. Many seniors feel frail because they are frail. They have become too weak, too stiff and too unsteady to live without fear of falling.

According to Dr. Donald Paterson of the School of Kinesiology, University of Western Ontario, healthy older adults need to do exercise which is "moderate to moderately vigorous, 30 minutes per day, four to five times a week" in order to reap maximum health benefits. This activity should be in addition to the light activities frequently performed during daily life, such as household work, casual walking or activities of very short duration. The Committee has heard that encouraging even a small segment of the

population to follow these directives would have an immense economic and societal impact. Dr. Paterson suggested that "it may be more effective to encourage exercise habits by starting with the groups most likely to comply and have these groups set a societal norm or standard that the more resistant types may follow."

Sedentary seniors say they already know exercise is good for you, but they do not feel it is good for them. The underlying issue may be self-imposed ageism.

> Chad Witcher, Representative, Alberta Centre for Active Living

It is unlikely that the majority of adults who are not physically active can be urged to meet the optimal level of physical activity outlined above. Chad Witcher of the Alberta Centre for Active Living described the challenge this way:

Healthy sedentary older adults say that they obviously do not need fitness to be healthy, while unhealthy seniors say that it is too late for them, that they are too old or not well enough to participate.

Evidence, April 28, 2008

Active Living Careful consideration needs to be given to how to promote the benefits of physical activity among adults, and how to communicate the message that it is never too late to start moving. Such a message needs to be tailored to groups who are less likely to be active. For example, older women are

significantly less likely than older men to be physically active. Other groups which are less likely to be physically active are seniors over age 80, seniors with low incomes and/or low education levels, seniors with disabilities and/or chronic health conditions, seniors who live in institutions or in isolation, and seniors who are members of ethnocultural and ethnolinguistic minority population groups.⁸⁴

The important role of physical activity in maintaining physical and psychological health, in reducing the risk of chronic disease, and in management of pain in chronic disease needs to be actively promoted to all Canadians, including seniors. The Committee urges the federal government to embark on a highly visible national social marketing campaign that uses mass media

The Committee urges the federal government to embark on a highly visible national social marketing campaign that uses mass media channels to reach a large segment of the population to educate on the benefits of physical activity for older adults

channels to reach a large segment of the population to educate on the benefits of physical activity for older adults.

Such a campaign should focus on the advantages of exercise. The Committee has heard that "fear-based messages that a person may fall or be at risk for a medical condition are not generally successful for behavioural change. People usually think they are not at risk and that these messages do not apply to them."

According to the Active Living Coalition for Older Adults, there are a number of barriers which make it difficult for seniors to be more

physically active, including physical accessibility of programs, the suitability of programs for seniors, the costs involved in the program and in the transportation to get to the program, and lack of motivation.⁸⁶ The physical environment can also play an important

The Committee urges the federal government to actively publicize best practices and innovative models on physical activity and seniors.

Health Canada, Physical Activity and Older Adults, Division of Aging and Seniors, 2002.

⁸⁵ Colin Milner, Chief Executive Officer, International Council on Active Aging, *Evidence*, May 7, 2007.

Active Living Coalition for Older Adults, Response to Committee's Questionnaire for Seniors' Organizations.

role in either preventing or encouraging physical activity. Facilitating physical activity means ensuring that neighbourhoods feel safe, communities are walkable, and sidewalks are free of snow and ice.

There are already many initiatives to increase physical activity among older Canadians. For example, model exercise programs and leader training programs have been developed at the Canadian Centre for Activity and Aging.⁸⁷ The Committee has heard, however, that there is insufficient information sharing at the national level. Witnesses have called for a mechanism to share best practices. As Colin Milner of the International Council on Active Aging told the Committee "many people are working in the dark." As a result, the Committee urges the federal government to actively publicize best practices and innovative models on physical activity and seniors.

4.1.3 Educational Opportunities and Lifelong Learning

Research shows that people who have been learning throughout their lives don't stop because they are seniors. Some, who

Active learning helps maintain brain health by preventing loss of brain function and cognitive skills such as memory, reasoning and judgment. This discovery has important implications for the prevention and treatment of dementia.

Marjorie Wood, Creative Retirement Manitoba have been unable to access learning opportunities during their working lives, take advantage of retirement to learn a new skill. As in the general adult population, the learning needs and styles of seniors vary widely. All of society benefits, however, by meeting these needs.

Much of the emphasis on education for adults has been linked to implications for workproductivity. place It has been clearly demonstrated that older workers significantly under-represented in job-related training provided by employers in Canada. Learning has a value beyond its application in the work force, however. Recognizing the

benefits of lifelong learning has to go beyond the implications for the labour force, to a focus on the significant benefits for the individual and the larger society.

Dr. Donald Paterson, Professor, School of Kinesiology, Faculty of Health Sciences, University of Western Ontario, Evidence, April 28, 2008.

The Committee has heard that "lifelong learning is linked to both longevity and quality of life. It helps seniors develop new interests and stay actively involved in the community. They feel happier, healthier, more respected and more independent when they are actively involved in learning." ⁸⁸ Active learning has also been linked to maintaining cognitive skills such as memory, reasoning, and judgement.

People are more likely to take advantage of learning opportunities in their senior years if they have continued to participate in learning throughout their lives. They are likely to pick up learning in their senior years at the level at which they finished formal training earlier in life. The senior years can also provide an opportunity to improve literacy skills, which are so important to daily life, as noted by Faye Martin, Acting Director of the Prince Edward Island Seniors' Secretariat:

We are aware that many of our seniors disenfranchised because of their literacy levels. These seniors are unable to partake in educational and learning opportunities have difficulty reading and prescriptions.

Evidence, May 13, 2008

The Committee has heard from several innovative continuing learning programs from seniors across the country.

Seniors Colleges and Universities across the Country

The Committee has heard from some of the programs which have been developed to meet the learning needs of seniors. The Seniors College of Prince Edward Island has 527 members who have unlimited access to a wide diversity of peer learning courses on issues as diverse as family history, astronomy, Math Magic, life writing and singing. Acadia University offers Acadia Lifelong Learning for older adults which allows older adults to audit any course taught at the university and have full use of Acadia library. In the twenty years of its existence, The Elder Learners Program in Halifax has offered more than 120 lectures to approximately 12,000 seniors. Université de Sherbrooke's Université du troisième âge was the first seniors' university in North

Marjorie Wood, Executive Manager, Creative Retirement Manitoba, *Evidence*, May 7, 2007.

America. It offers non-credit courses to people over the age of 50 who are interested in taking courses for the sheer pleasure of learning.

Educational programs have the added benefit of allowing people to socialize as they learn together. It is important to ensure that there is a wide range of opportunities, meeting the needs of men and women of varying educational backgrounds. The Committee heard about an innovative program in Australia to provide an educational experience to men.

Men's Sheds Project, Australia

Men's Sheds are informal learning environments, structured around woodworking and metalworking activities, which give older men opportunities for socializing. Typically located in shed or workshoptype spaces in the community, they are engaged in activities such as rehabilitating old bicycles and old wheelchairs, which are then donated to persons in the community who would not otherwise be able to afford them. This is proving to be a very significant approach to engaging men in learning in Australia, attracting older men that have proved difficult to engage through conventional health, employment, education and training initiatives. Many of these older men are facing issues associated with significant change, including ageing, health, retirement, isolation, unemployment, disability and separation.

In its response to the Committee's questionnaire, the Seniors College of Prince Edward Island recommended that there be "annual support for enhancing communications among the provinces on the topic of lifelong learning for 50+. This should involve both grass roots level organizations and ministries involved with seniors." The Committee emphasizes the importance of promoting information-sharing among providers of lifelong learning opportunities for seniors across the country, and recommends:

17. That the issue of lifelong learning for seniors be put on the agenda of the next meeting of the Council of Ministers of Education and the Federal, Provincial, Territorial Ministers Responsible for Seniors.

Response of the Seniors College of Prince Edward Island to the Committee's Questionnaire for Seniors' Organizations.

The Committee encourages efforts to make educational opportunities for seniors as affordable as possible. Some witnesses have suggested that tuition should be free for seniors. Others have supported the extension of existing educational tax credits to seniors. These tax credits are currently provided to those studying full-time in post-secondary courses or toward improving skills in an occupation at an educational institution that has been certified by Human Resources and Social Development Canada. Witnesses in the second phase of

the committee's study suggested that these measures be expanded for those over the age of 65 to include a broader definition of eligible courses. Committee has heard conflicting testimony on this subject. On the one hand, witnesses highlighted that tax credits are geared to higher-income seniors, for whom cost may not be a Others, however, feel that educational tax credits would help defray the costs of learning for seniors. The

The Committee urges the federal government to study the possibility of extending the educational tax credits to seniors, with a particular focus on determining whether this would have the potential to increase the uptake of educational programs by seniors.

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4.2 Age-Friendly Cities and Rural Communities

With the aging of the Canadian population, our communities - cities, towns and villages - will need to be more senior-friendly. This means that they will have to be more responsive to seniors' needs in terms of enabling them to go to the places they need and want to go to and to participate in recreational, social and community activities, and access the types of support services they need. The overall aim will be to create communities that are accessible, welcoming, enriching and supportive of seniors' overwhelming desire to remain independent for as long as possible.

Luis Rodriguez, Senior Researcher, Canada Mortgage and Housing Corporation, *Evidence*, December 10, 2007

The Committee emphasizes the importance of making cities and rural communities more accessible to seniors so that they can continue to be active participants in society.

The World Health Organization released its *Global Age-Friendly Cities Guide* in October 2007. This guide provides a model to prepare cities to support growing populations of active, older adults. It includes suggestions related to outdoor spaces and buildings, transportation, housing, social participation, respect and social

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inclusion, civic participation and employment, communication and information, and community and health services (see Appendix 1 for the Checklist of Essential Features of Age-Friendly Cities). In Canada, the model of the age-friendly city was adapted for use in rural and remote communities through the development of an *Age-Friendly Rural and Remote Communities Guide*.

The Global Age-Friendly Cities Guide and the Age-Friendly Rural and Remote

Communities Guide provide accessible tools to help communities make the changes needed to become more age-friendly. Making cities more age-friendly makes them more user-friendly for all residents, not only seniors. As the Hamilton Council on Aging outlined in its brief to the Committee:

Creating a truly Age Friendly City – fully implementing the model – is a long-term process. We feel it will entail a 10-year change process, one that will gather momentum as it proceeds. This kind of process needs leadership and support from all levels of government but its success will depend on inspiring commitment and participation at the most local of levels, the neighbourhood. ⁹⁰

Designing age-friendly cities means finding a way to ensure that seniors' voices will be heard. Many witnesses have underlined the importance of involving community and seniors' organizations in the

Hamilton Council on Aging, A Response to the Special Senate Committee on Aging – Second Interim Report: Issues and Options for an Aging Population, May 9, 2008.

implementation of the Age-Friendly Cities and Rural and Remote Communities models. Elaine Gallagher, Director of the Centre on Aging, University of Victoria, suggested that having active local advisory councils comprised of seniors allows their voice to be heard in decision-making about where municipal dollars are directed and what public works are needed to make the community friendlier for them.

Communities across Canada have expressed an interest in moving toward the implementation of these age-friendly guidelines.

Some are receiving support from their provincial governments. Others are seeking support from other funding sources. We heard, for example, that the Hamilton Council on Aging had put in a grant application with the Trillium Foundation for three-year funding that would allow a move toward implementation of the Age-Friendly Cities guidelines.

If a majority of senior citizens live in communities where one needs a car to be able to function, what happens when we get too old to drive?

The governments of some provinces, including Nova Scotia, Quebec, Manitoba and British Columbia, have moved to support municipalities in the implementation of the Age-

Glenn Miller, Director, Education and Research, Canadian Urban Institute

Friendly Cities and Communities guidelines. The implementation programs which have been presented to the Committee include:

- The Government of Quebec's Age-Friendly Cities Project is providing funding for seven pilot projects for municipalities to work with seniors to ensure that policies, services, and social and physical infrastructure are designed to support seniors to allow them to age actively.
- British Columbia's Ministry of Health has recruited an Age-Friendly Communities Implementation Team to help local governments identify barriers and implement actions to create age-friendly communities. The Team will provide expert planning advice and support to local governments (including municipalities, regional districts and Aboriginal communities) to develop and implement age-friendly actions.⁹¹ The goal is to make BC the most age-friendly jurisdiction in Canada by 2010.

These guides include user-friendly documents such as *How Age-friendly Is Your Community?* at

 The Union of British Columbia Municipalities has made a grant of \$5,000 available to any community that wants to conduct an assessment of its age-friendliness. An additional \$35,000 grant is available to fund community projects that are age-friendly, such as making more public washrooms available for older people. ⁹²

Witnesses suggested that these initiatives could be strengthened and expanded with the federal government's participation. Federal government support could go a long way in ensuring that the age-friendly guidelines are implemented in as many communities as possible throughout the country. This is why the Committee recommends:

18. That the federal government actively promote both the Age-Friendly Cities Guide and the Age-Friendly Rural and Remote Communities Guide to seniors' organizations, provincial governments, and municipal governments; and That it provide financial assistance to support the implementation of the Age-Friendly Cities and the Age-Friendly Rural and Remote Communities guidelines.

This could either take the form of providing financial support to joint initiatives between seniors' organizations and municipal governments which have committed to a process of implementing these guidelines, or of a transfer to provinces to allow them to fund such initiatives.

4.3 Universal Design

Accessible building design and standards have existed in Canada for many years. The Committee has heard that accessibility standards need to be extended beyond housing to the full range of everyday products and services, including the way the government

<u>http://www.seniorsincommunities.ca/upload/dcd188 Start Up Guide.pdf</u> and the <u>Checklist of Essential Features of Age-friendly Cities at http://www.seniorsincommunities.ca/upload/dcd174 Age friendly cities checklis</u>

Elaine Gallagher, Director, Centre on Aging, University of Victoria, *Evidence*, April 28, 2008.

communicates with Canadians. Glenn Miller of the Canadian Urban Institute told the Committee:

Good design works well for people of all ages, but for those with mobility problems or with sensory or cognitive impairments it can make the difference between independent living and social exclusion. It is not just lifetime homes that are needed, but lifetime neighbourhoods, where older people are not left out or forgotten because they cannot access buildings or public spaces ... They are neighbourhoods where transport, good shops, green spaces, decent toilets and benches are consciously planned.

Good design is good design: If we have good design for older people, then we generally have good design for children. Age-friendly is not only for seniors but also for others in the community.

Margaret Gillis, Division of Aging and Seniors, Public Health Agency of Canada

Evidence, April 28, 2008

While not all older persons have disabilities, the prevalence of disability or limitations is highest among this demographic group. The issue of usability of products and services has become more critical with the increasing percentage of older persons in the world's population. Usability is broader than the concept of accessibility of buildings, incorporating such issues as the accessibility of information.

For example, a reliance on web-based information assumes a basic level of literacy and people's ability to access the internet. The Committee has heard that "the government must broaden its thinking and realize that it cannot put all of its resources into web-based information; it has to think about people who do not have access."

The Committee urges the governments to adopt the principles of universal or inclusive design to guide the actions of all government departments.

This message was also conveyed in testimony from Aboriginal organizations and immigrant communities.

European Committee for Standardization, CEN/CENELEC Guide 6 Guidelines for Standards Developers to Address the Needs of Older Persons and Persons with Disabilities.

Glenn Miller, Director, Education and Research, Canadian Urban Institute, Evidence, April 28, 2008.

The Committee has heard that some countries, such as the United Kingdom and Japan, have moved toward a more concerted effort to ensure that products and services are designed to meet the needs of the widest range of people. Innovative projects also exist in Canada, such as the implementation of "visitability" standards in British Columbia.

Visitability

A group of 41 communities in Northern British Columbia have come together and decided to adopt the concept of visitability. It dictates that you must be able to have anyone with any disability visit your home for a period of three to four hours with no problem. That means there should be a washroom on the ground level, the front entranceway cannot have stairs and the doors should be wide enough to accommodate a wheelchair. That is it — three concepts. Therefore, all new housing in those 41 communities will be required to have visitability standards right at the beginning of construction in order that anyone with any disability could comfortably go to any home for a visit.

Elaine Gallagher, Centre on Aging, University of Victoria

The Committee urges the governments to adopt the principles of universal or inclusive design to guide the actions of all government departments.

4.4 Transportation

Transportation is one of the key components of age-friendly communities, and is a subject which came up often in this Committee's discussions with seniors. Transportation is a key issue to supporting seniors in their own homes and to ensuring that they have access to health and social services.

Seniors rely on a number of transportation options. Many continue to drive, sometimes altering their driving behaviours as they get older. Public transportation is a viable option for seniors in many larger cities. Still others rely on accessible transportation, volunteer drivers, or friends and family members. Each of these issues presents challenges.

Seniors with mobility challenges or dementias are confronted with particular challenges. Lack of adequate, accessible transportation choices can leave a senior socially isolated.

Many cities provide accessible public transportation get seniors medical to to appointments, but the limited availability of these services means that not all needs are being well served. The Committee has heard that, in some areas for example, "paratransit services will not allow a person with Alzheimer's on with their caregiver if they are mobile. Unless the person has a physical disability, they are excluded." In other areas, accessible transportation is only available to drive people to medical appointments, making it

A senior's independence, physical, emotional and social health as well as the ability to remain engaged in the outside world is dependent on one or another mode of transportation.

Brief, Ottawa Seniors Transportation Committee

impossible for them to access other community supports and activities. Some jurisdictions, including British Columbia and Calgary, have put in place measures to ensure low-cost public transportation for seniors.

Innovative Transportation: BC Bus Pass Program and the Senior Citizen's Transit Pass in Calgary

The BC Bus Pass Program provides affordable transportation to low-income seniors and persons with disabilities in 44 communities in British Columbia and benefits more than 60,000 persons per year. To be eligible for the yearly 45 dollar pass, a senior must be receiving Old Age Security and either the Guaranteed Income Supplement, or the Spousal Allowance. The Calgary Transit Senior Citizen's Transit Pass provides unlimited access to transit services for persons 65 years and over for \$35 per year. Low-income seniors can get a Transit Pass for \$15 per year.

Transportation issues in remote and rural communities are different from those in urban areas. Rural seniors often have no public transit available to them, and are dependent upon others for assistance. Many of these seniors must travel great distances for health care and appointments. Kimberly Wilson of the Canadian

⁹⁵ British Columbia, Premier's Council on Aging and Seniors' Issues, *Aging Well in British Columbia: Report On Progress*, July 2007.

Coalition for Seniors Mental Health reported that their members who work in rural areas have told them that transportation remains the most relevant barrier to care and services for older adults in rural areas.

Some programs in urban areas rely on volunteer drivers to pick up seniors; however, this renders those programs inaccessible to those

Unless you have a family member or a friend to drive you, you are homebound for a great deal of time during the harsh winter months.

Elaine Gallagher, Director, Centre on Aging, University of Victoria in rural areas. For example, the Hospice at May Court in Ottawa commented on access to its program for rural residents:

Our biggest challenge would be recruiting volunteer drivers from those communities. Our drivers mainly come from the Ottawa area, therefore the Day Hospice program we offer may not be accessible to some of the patients living in rural areas.⁹⁶

The Committee has heard that transportation needs differ from community to community. In addition, witnesses have noted that some of the solutions are not costly – at times, what is called

for is simply a reorganization of existing services.

Communities across the country are identifying strategies to help them address the transportation needs of their older residents. As with the other components of age-friendly communities, the transportation needs of seniors can best be addressed in collaboration with seniors and their organizations. One example of such of a collaborative effort is the Ottawa Seniors Transportation Committee.

The Ottawa Seniors Transportation Committee (OSTC)

Non-government organizations, such as the OSTC partnership, are grass-roots community and reality based. They see first-hand the needs and pressures created by the lack of affordable or available transportation. Collaborative community partnerships can develop innovative and constructive approaches to these issues that are timely, practical and affordable. A partnership group can advocate and speak with a strong voice – and be heard.

Hospice at May Court, Response to Questionnaire from the Special Senate Committee on Aging.

There are no one-size-fits-all approaches to addressing the transportation needs of seniors. If it were to support the implementation of age-friendly communities, as recommended by this Committee above, the federal government would allow communities to tailor solutions to meet their needs. In Chapter 7 we will explore ways the federal government can support the voluntary sector, which is an active partner in providing transportation to some older seniors.

Chapter 5: Eliminating Poverty

As one of its broad themes, the Committee has chosen to focus specific attention on the elimination of poverty among older Canadians. The Committee has heard that poverty among seniors has been reduced radically in recent years; in fact, Canada's income security system for seniors has resulted in the lowest incidence of low income among all developed countries.⁹⁷

While in general terms seniors' incomes have increased significantly over the past few decades, this trend has not resulted in the elimination of poverty among Canadian seniors. Using Statistics Canada's low income cut-off lines as a proxy for poverty, Table 5.1 shows how different households have fared in that time. Low income cut-off lines are developed by Statistics Canada, based on an income in which a household will spend 20 percentage points more of their income on basics than the average household would spend. It varies by the size of community and number of people in the household. The before-tax calculation is the figure based on income before any taxes are charged or tax credits are paid.

Table 5.1 - by family type, Canada, selected years

	1980	1984	1988	1992	1996	2000	2003	
	percent							
Low income cut-off before tax (1992 base)								
Married couples	20.1	15.9	12.8	8.3	7.8	4.9	5.3	
Unattached individuals – Total	69.2	64.3	56.5	50.5	47.2	42.6	38.4	
Unattached individuals – Men	61.0	55.6	39.4	36.0	35.7	34.0	31.7	
Unattached individuals – Women	72.2	67.0	61.7	55.2	51.1	45.8	41.0	
Low income cut-off after tax (1992 base)								
Married couples	5.9	4.7	3.9	1.7	2.0	1.2	1.7	
Unattached individuals – Total	54.4	40.8	31.7	25.9	25.4	20.6	17.7	
Unattached individuals - Men	47.0	32.6	18.7	16.9	19.8	17.6	14.7	
Unattached individuals – Women	57.1	43.4	35.6	28.8	27.3	21.6	18.9	

Sources: Statistics Canada, Survey of Consumer Finances; Survey of Labour and Income Dynamics.

Source: Martin Turcotte and Grant Schellenberg, *A Portrait of Seniors in Canada -2006,* Statistics Canada, 2007, p. 95.

This table demonstrates that all groups have seen improvements over time, but not equally, and that fewer seniors are poor after receiving tax-related benefits.

⁹⁷ Low-income is measured in many ways; in this case, as is often true in international comparisons, low-income applies to incomes below one-half the median income for the nation.

Although not evident in this table, the Committee heard there are differences among seniors with respect to both how many are poor and how poor some groups are compared to others. Economist Michael Veall explained this to the Committee:

If you look at the data, you find that most of the seniors who are below LICO [low income cut-off] are not far below LICO so that the depth of the poverty is not as great. The groups experiencing deep poverty as seniors are basically three. One group includes immigrants who do not yet qualify for the Guaranteed Income Supplement. The second group is seniors who have dependent children, in some cases grandchildren or disabled children they support. The third group is people who do not take up GIS even though it appears from the data that they qualify for GIS. We do not understand why that is so, that is an empirical puzzle with important consequences.

Evidence, April 14, 2008

The income system for seniors is said to be composed of four pillars: the Canada Pension Plan or Quebec Pension Plan (CPP/QPP), employer-sponsored pensions, Old Age Security/Guaranteed Income Supplement (OAS/GIS) and private income from earnings and savings. Taken together, these pillars meet the income needs of most but not all Canadian seniors.

5.1 Pensions

Pensions, both CPP/QPP and employer-sponsored, can be seen as deferred earnings with employers and employees making contributions over a working life and benefits flowing after retirement, with a pre-determined minimum age for drawing benefits (generally 55 in private plans, and 60 for CPP/QPP).

Pension income varies with the number of years paying contributions and the level of income over those years.

Silvana Pozzebon, *The Future of Pensions in Canada*, Pension Research Council Working Paper 2004-15, Wharton School of the University of Pennsylvania, 2004, pp. 2-3.

5.1.1 Employer-sponsored pensions

Private pension plans are offered by some employers, and historically have provided commitments of a defined benefit based on earnings and the amount of contributions paid by the employee. Coverage by such plans increased significantly starting in the 1970s, resulting in almost 70 percent of men over 65 receiving private pension income in 2003, and 53 percent of women.⁹⁹

In recent years, the Committee learned, there has been a shift in many such plans, especially in the private sector, from defining the benefit paid out to defining the contribution paid into the plan, with the benefit level being the product of the return on investment of the contributions paid. The net effect is to shift the risk from employers to employees, which could increase the income insecurity of seniors as they retire.

Further insecurity, the Committee heard, is anticipated as more Canadians, especially women, are in non-standard work and may not have any coverage. Moreover, the rate of changes in jobs over a lifetime means that private pensions may not accumulate significant benefits. Witnesses told the Committee that only 40 percent of Canadians, and only one-third of Canadians outside the public sector, now participate in employer-sponsored plans.

Therefore, while an increasing amount of income for Canadian seniors is coming from private pension benefits, we have heard that this increase may not continue and the income level from this source will become less secure in the coming years.

5.1.2 Canada/Quebec Pension Plans

The publicly administered plans – CPP/QPP – have required contributions from employers and employees since their inception in 1966. As the plans have now fully matured, most older Canadians (95 percent of men and 85 percent of women) receive CPP/QPP benefits, which accounted for about 20 percent of their total income in 2003. 100

¹⁰⁰ Martin Turcotte and Grant Schellenberg, *A Portrait of Seniors in Canada – 2006*, Statistics Canada, 2007, p. 94.

⁹⁹ Martin Turcotte and Grant Schellenberg, *A Portrait of Seniors in Canada – 2006*, Statistics Canada, 2007, p. 66.

Between September and December of 2008, just over 5 million people will receive CPP benefits, and almost 1.7 million will receive QPP benefits.¹⁰¹

These benefit levels (\$4,900 for women on average, and \$6,500 for men on average in 2003)¹⁰² are based in part on their contributions while working and the level of their pay and contributions. However, they are also limited by parameters of the program that dictate that the maximum benefit payable is 25 percent of the average industrial wage.

Particularly in light of the changes occurring in the kind of jobs available and the benefit plans in private pensions, the Committee was interested in recommendations from witnesses to increase the possible income replacement rate or the maximum earnings on which the rate is applied. Several witnesses suggested increasing the maximum pensionable earnings from approximately \$40,000 to \$60,000, while others suggested doubling the replacement rates. Several witnesses also flagged the multiple impacts such a change would have, even if it were implemented over time.

CPP design has impacts beyond the level of retirement income. Its design permits individuals to draw their benefits beginning at age 60 (with a slight reduction in the benefits for each year before the age of 65) and as late as at age 70 (with a slight increase in benefits for each year after the age of 65). To begin to claim benefits, an individual must be receiving no employment income, although he or she can earn income again after benefits begin to flow.

While the range in age for claiming benefits is intended to encourage choice, witnesses told the Committee that it has the opposite effect, creating a financial incentive to early retirement. For those concerned with labour shortages, the Committee heard, this incentive is problematic and should be offset with increased incentives to delay the start of benefits. Those concerned with low-income older workers who are unable to sustain their full-time jobs, however, argued that the penalty for early take-up should be abolished. Still

Service Canada, "Income Security Programs Information Card", Accessed from http://www.hrsdc.gc.ca/en/isp/statistics/rates/julsep08.shtml November 21, 2008.

¹⁰² Martin Turcotte and Grant Schellenberg, *A Portrait of Seniors in Canada – 2006*, Statistics Canada, 2007, p. 66.

others emphasized that it is not productive to require people to leave their jobs in order to begin their benefits.

The Committee is committed to both increasing choice and eliminating poverty, and sees the CPP/QPP as mechanisms for doing both. In recognition of the technical and intergovernmental nature of changes to the CPP, the Committee recommends:

- 19. That in their next triennial review of the CPP, the Ministers of Finance consider:
 - Increasing the income replacement rate for the CPP (currently 25 percent of allowable income);
 - Increasing the maximum pensionable earnings above the average wage;
 - Investigating actuarial adjustments to the Canada Pension Plan to increase the incentive to delay uptake;
 - Examining mechanisms to allow older workers who begin to collect CPP before age 65, but who are not receiving the maximum benefit, to continue to contribute to the CPP;
 - Eliminating the requirement in the CPP that individuals between the ages of 60 and 65 who apply for CPP must quit work or earn up to the maximum of CPP in the months prior to the application; and
 - Introducing a drop-out provision for caregivers.

Finally, the Committee heard that those with the least earnings and the least stable employment will receive the least benefit from this plan. This group includes those who are over-represented among the working-age poor: newcomers to Canada, Aboriginal peoples, and sole-support parents, most of whom are women.

Thelma McGillivray of the Older Women's Network told the Committee:

By the numbers, women are poorer than men, not to deny that there are poor men, and this bodes badly for the future generations as they also age. This is due to a number of often repeated factors: women's lower earnings throughout their lifetime, child-rearing responsibilities and lack of a national child care program, coupled with traditional patterns of paid and unpaid work reflecting lower incomes in retirement.

Evidence, May 9, 2008

Similarly, Derek Hum of the University of Manitoba told the Committee about why immigrants may expect lower CPP benefits than other beneficiaries:

The recent experience of immigrants is what we should be concerned with. In the last couple of decades, immigrant earnings have not converged as quickly as in the past. Some estimates ... suggest that the gap has also been growing ... and suggests that these immigrants never catch up in their lifetime.

Evidence, February 11, 2008

The Committee notes that the current design of CPP will not provide sufficient economic security for women, immigrants and others who face systemic barriers in the economy.

5.2 Savings¹⁰³

On average, the private income sources for seniors derive almost entirely from private pension benefits, with less than 10 percent

The Committee ended its meetings with witnesses in the spring of 2008, before the economic slow-down in the fall of 2008 and the sharp decline in the value of the savings of many seniors. Although the Committee has not heard evidence on the impact of the erosion of seniors' investments, it highlights the necessity of implementing measures to minimize the deleterious effects the current economic and market conditions are having on older Canadians.

coming from Registered Retirement Savings Plans (RRSPs).¹⁰⁴ Lowincome seniors may not have had sufficient income when they were younger to accumulate significant savings. Further, RRSPs offered no real incentive to this group of seniors, as their income was so low as to be exempt from taxation or taxed at the same level it would be taxed later in their lives. Finally, until the recent positive changes made in Budget 2007, anyone receiving the income-tested Guaranteed Income Supplement (GIS) would have had half the value of any withdrawal from RRSPs deducted from their GIS benefits.

The RRSP provides an incentive to save by exempting contributions to the plan from income taxation in the year they were earned. Instead, taxes are paid when the income is withdrawn from the plan, encouraging participants to withdraw funds when their income (and tax level) may be lower. While this was designed to provide greater private income during retirement, the program does

not penalize or prohibit earlier withdrawals beyond the income becoming taxable, thereby allowing RRSP savings to be used to even out income flows during any period of lower income.

The traditional school-work-retirement life-course is gradually being replaced by greater diversity of trajectories into and out of paid employment. It is conceivable that this will continue into the future, altering the meaning of

The Committee believes that while retirement savings may be impossible for those with low incomes, RRSPs may help even out fluctuating incomes.

retirement and calling for policy measures which will facilitate choices about when to study, work, provide care and retire. The life-course approach to program and policy design is premised on the notion that employment and income will vary over the life course, with individuals and households needing more non-working time at some times than others, and will have more or less income at different times. The fact that more than 40 percent of those drawing funds from employer-sponsored pension plans and RRSPs are under the age of 65¹⁰⁵ suggests that RRSPs are being used to even out bumps in employment and income over the life-course, and not only for retirement income. Although RRSPs provide for this flexibility, the Committee has heard

¹⁰⁴ Martin Turcotte and Grant Schellenberg, *A Portrait of Seniors in Canada – 2006*, Statistics Canada, 2007.

¹⁰⁵ Finance Canada, cited in Policy Research Initiative, *Encouraging Choice in Work and Retirement: Project Report*, 2005, p. 16.

that most low-income Canadians do not invest, or invest little, in RRSPs.

5.3 Old Age Security/Guaranteed Income Supplement (OAS/GIS)

The public income security system provides one benefit to all seniors who meet the residency test (OAS) and another targeted to those with low incomes (GIS). Almost all seniors receive benefits from these programs¹⁰⁶ (95 percent),¹⁰⁷ while just over one-third receive GIS payments.¹⁰⁸

The maximum monthly OAS benefit for the period between October and December 2008 is \$516.96; the maximum monthly GIS benefit in the same period for a single senior is \$641.51. 109 Approximately 4.5 million Canadians will receive OAS payments in that period, of which 1.6 million will also receive either GIS or the spousal allowance (whether the regular allowance or that provided on the death of a beneficiary). 110

However, as noted above, the combined levels of OAS/GIS do not bring all seniors to the poverty line, particularly in larger communities. Further, when costs of basics rise faster than these benefit levels rise through indexation, many seniors are unable to afford their necessities. Recent spikes in food costs and fuel costs are examples.

¹⁰⁶ Both these programs have incomes above which benefits are reduced. For OAS, that amount is \$64,718; no OAS payments would be made to an individual with an income above \$105,266. For GIS, benefits to those with incomes above \$37,584 would be reduced. However, this chapter is focussed on eliminating poverty, and therefore does not refer to those who do not receive benefits because their incomes exceed the limits in the program.

¹⁰⁷ Martin Turcotte and Grant Schellenberg, *A Portrait of Seniors in Canada – 2006*, Statistics Canada, 2007, p. 66.

National Advisory Council on Aging, *Aging in Poverty in Canada*, 2006, p. 12.

Service Canada, "Income Security Programs Information Card". Accessed from

Service Canada, "Income Security Programs Information Card". Accessed from http://www.hrsdc.gc.ca/eng/isp/oas/oasrates.shtml November 24, 2008.

Service Canada, "Income Security Programs Information Card". Accessed from http://www.rhdsc.gc.ca/eng/isp/statistics/rates/octdec08.shtmlNovember 24, 2008.

The Committee recommends:

20. That the Government of Canada increase the Guaranteed Income Supplement to ensure that economic households are not below the poverty line as defined by the low income cut-off levels. Increases to the GIS should not result in the loss of eligibility for provincial/territorial subsidies or services for seniors.

5.3.1 Access

Despite the large number of Canadians receiving these benefits, the Committee heard from witnesses that it is those who do NOT receive these benefits who have the lowest incomes. The Committee heard that the two largest groups not receiving these benefits are immigrants who have not been in Canada long enough to qualify for these programs and those who have not applied for benefits, despite being qualified to receive them.

Immigrant Seniors

During the course of this study, the Committee learned that immigrant seniors are particularly at risk of living in poverty. According to the 2003 Canadian Community Health Survey, 26 percent of immigrant seniors were in the lowest income quartile compared to 15 percent of non-immigrant seniors. This is a result in part of the double disadvantage they face within the Canadian pension system.

First, as noted above, immigrants are unable to make as many contributions to the Canadian Pension Plan (CPP) as their Canadian-born counterparts, as they experience lower levels of income over the course of their lifetime. They are not able to contribute to the CPP as often, or at the same income levels, as their Canadian counterparts and therefore end up with lower levels of pension income in retirement.

Second, immigrants also face barriers to Canada's non-contribution pension programs such as OAS and GIS due to the residency requirements of these programs. To receive the OAS, one must be a Canadian citizen or a legal resident 65 years of age or older and have resided in Canada for a minimum of 10 years, after reaching

the age of 18. A full OAS pension is only available to those who have lived in Canada for 40 years or longer.

However, a partial OAS pension is available to those who may not meet the requirements for a full OAS pension. A partial pension is earned at the rate of 1/40th of the full monthly pension for each year an individual has lived in Canada after reaching the age of 18. Similarly, the GIS is available only to those receiving the OAS.

To address these barriers that immigrants face in accessing pension income, as well as to ensure that Canadians living abroad were able to have access to benefits, the Government of Canada began negotiating international social security agreements in 1977. Through the totalizing arrangement of these agreements, immigrants would be able to receive benefits from their home country's social security program, as well as qualify sooner for partial OAS and GIS benefits in Canada.

To date, Canada has signed 50 social security agreements, 48 of which are currently in force. These agreements have been concluded with five of the ten top source countries of new permanent residents in 2006, namely the Philippines, United States, United Kingdom, Republic of Korea and France.

While witnesses acknowledged the importance of reciprocal social security agreements for the income security of immigrant seniors, they also noted that this did not ease the economic burden of immigrant seniors from source countries without reciprocal agreements such as India, Pakistan and Sri Lanka.

The Committee reiterates the importance of reducing the residency requirement for OAS, as recommended in Chapter 1 of this report.

This has led some to advocate that the eligibility criteria for OAS should be based upon citizenship rather than the number of years a person has resided in Canada. In a questionnaire submitted to the Committee, Women Elders in Action articulated that "once a person becomes

a Canadian citizen, he/she should be entitled to benefits." This is consistent with a research article that concluded that a citizenship-based approach to benefits would "substantially increase the

retirement income of recent immigrants."¹¹¹ The Committee reiterates the importance of reducing the residency requirement for OAS, as recommended in Chapter 1 of this report.

Non-applicants

The Committee was especially concerned to learn that significant numbers of seniors who are qualified for benefits are not receiving them because they are not applying for them, or are being disqualified for not following application procedures.

This issue is not new. The Standing Committee on Human Resources Development and the Status of Persons with Disabilities tabled a report in 2001 entitled "The Guaranteed Income Supplement: The Duty to Reach All." At that time, Statistics Canada reported that 84 percent of eligible seniors were receiving GIS, but among those who needed to apply (because they did not file taxes, and were therefore not automatically registered to receive benefits), only 41 percent had applied. 112

In response, the department responsible for delivery of these benefits began its concerted efforts to reach all eligible seniors to ensure they were aware of their entitlements. These efforts included targeted mailings to seniors reporting low income on tax forms, outreach at seniors' meetings and events, and a national ad campaign that reached print and television audiences, including community newspapers and media targeted to seniors. The Department reported that the campaign resulted in more than 17,000 calls.

Because GIS benefits are income-tested, annual renewal requires information about the income of beneficiaries. In 2006, the Auditor General reported on OAS/GIS, noting that steps taken to improve take-up rates included automatic renewal of GIS benefits for

Preston Poon, "Who's missing out on the GIS?", Perspectives on Labour and Income, Vol.6, No.10, Statistics Canada, October 2007, p. 9. Accessed from http://www.statcan.ca/english/freepub/75-001-XIE/11005/art-1.pdf, June 27, 2008.

Patrik Marier and Suzanne Skinner, "The Impact of Gender and Immigration on Pension Outcomes in Canada," Paper Presented to the Annual Canadian Political Science Association, Saskatoon, May 30th-June 2nd 2007, p. 12.

Human Resource Development Canada Performance Report For the period ending March 31, 2003. Accessed from http://www.tbs-sct.gc.ca/rma/dpr/02-03/HRDC-DRHC/HRDC-DRHC03D-PR e.asp?printable=True, May 28, 2008.

tax-filers and mail-out of renewal notices to other beneficiaries. As well, in May 2007, legislation was passed to allow OAS applicants to apply only once for both OAS and GIS benefits; as a result, if a senior's income goes above the income threshold for GIS one year and then below the next, he or she does not need to re-apply.

Despite these efforts, the Committee heard of too many eligible seniors who are not receiving benefits to which they are entitled. Marjorie Wood of Creative Retirement Manitoba, told the Committee:

... the number of people not applying for the GIS indicates a larger systemic problem. It is my view that those people have simply fallen between the cracks. They might think they do not have to file a tax return because they are not earning any money. They might be living at the poverty level or so far below it that they do not file a tax return and therefore do not receive the benefit. We will never know about them if we do not have some information about them. How would you reach such people when they are at that level of existence?

Evidence, May 7, 2007

A brief from the Assembly of First Nations, where take-up rates

The Committee believes that increasing access to these benefits for those entitled to receive them is an important step in eliminating poverty among seniors.

are lower than for the population in general, identified two barriers to accessing benefits: lack of information that is clear enough to be useful and the complexity of the application process. Forms in English or French do not meet the needs of all First Nations people or immigrants.

Based on the evidence, the Committee believes that increasing access to these benefits for those entitled to receive them is an important step in eliminating poverty among seniors.

Office of the Auditor General, "Chapter 6—Old Age Security—Human Resources and Social Development Canada and Service Canada", *Report of the Auditor General*, November 2006.

Accessed from http://www.oag-

bvg.gc.ca/internet/English/aud ch oag 2006 6 e 14974.html#ch6hd3a, June 27, 2008.

Assembly of First Nations, "Sustaining the Caregiving Cycle: First Nations People and Aging", Submission to Special Senate Committee on Aging, May 2007, p. 19.

The Committee has also heard evidence that seniors who do not apply for benefits are often isolated and living alone with little social contact. Carolyn Rosenthal of the Hamilton Council on Aging told the Committee of her organization's efforts to reach the estimated 4,000 seniors in Hamilton who are not receiving the benefits to which they are entitled:

The best I can tell you at the moment is that working with local associations and neighbourhood groups, including faith-based organizations in some communities, has been helpful in leading us to individuals. But it is really turning over one stone at a time. It is a very painstaking process.

Evidence, May 9, 2008

This evidence confirms for the Committee the importance of non-government organizations and their volunteers in ensuring access to income security programs for low-income seniors. The role of volunteers is addressed in greater detail in Chapter 7 of this report.

The Committee also learned that when seniors do apply for OAS/GIS benefits, they are entitled to only 11 months of retroactive benefits. Similar restrictions on CPP retroactive payments apply. As those eligible for CPP are applying for benefits funded by employers and employees, and as OAS and GIS are intended to be anti-poverty measures for seniors, the Committee recommends:

- 21. That the federal government undertake aggressive campaigns to ensure that all eligible Canadians are receiving all retirement and age-related benefits. This means the government should:
 - Inform seniors of all possible federal sources of income supports when they apply for any one of them:
 - Make available to seniors application forms in aboriginal languages and the languages of larger immigrant populations; and
 - Make fully retroactive repayments with interest to eligible recipients who did not apply for OAS/GIS at 65 or CPP at 70, or who were denied benefits due to administrative errors.

5.4 Earnings

Witnesses have told the Committee that current pension regulations, combined with tax laws, create financial incentives for people to leave employment when their pension benefits have reached their maximum level, sometimes as early as age 55. In the interest of encouraging choice through neutrality in programs and eschewing ageism, the Committee has expressed its interest in removing disincentives and incentives in the retirement decision, as evidenced in the recommendations above. In so doing, the Committee is also cognizant of the wisdom of encouraging a life-course approach to earning and working. Terrence Hunsley of the Policy Research Initiative told the Committee:

We are recommending that we make this process of flexibility easier by removing some of the existing disincentives. They can be in the form of legislation affecting private pension plans or some of the ways in which the benefits are calculated.... The devil is in the details, but in looking at those details we can find many areas where we could be increasing the flexibility that both employers and individuals have in making decisions to work, to retire, to combine work and retirement and different kinds of activities at that stage of their lives.

Evidence, February 19, 2007

The Committee believes program changes are needed to allow greater flexibility in work and retirement decisions.

The Committee has also learned that the trend toward early withdrawal from the labour market (at as young as 55, with the average at 60) has been reversing in recent years, with more Canadians choosing to work to the age of 65 or beyond, especially among women, often part-time or self-

employed. Byron Spencer of McMaster University captured for the Committee how this could be a double-edged sword:

... there has been rather a sharp upturn in [labour force participation] rates for reasons that are not fully understood, but some of it might have to do with ... better health.... Certainly a lot of it has to do with the fact that there are jobs available for them if they do get displaced from their employment, there is something else they can go to because there has been generally quite good labour

market activity in this period. Also, their income security has been challenged a bit over this period, and so they are more anxious to remain in the labour force.

Evidence, November 6, 2006

At a conference in 2006, Dr. Spencer displayed the chart below, showing what role earnings play in the income of men aged 50 and older. The equivalent chart for women shows an even greater proportion of income from earnings in later years.

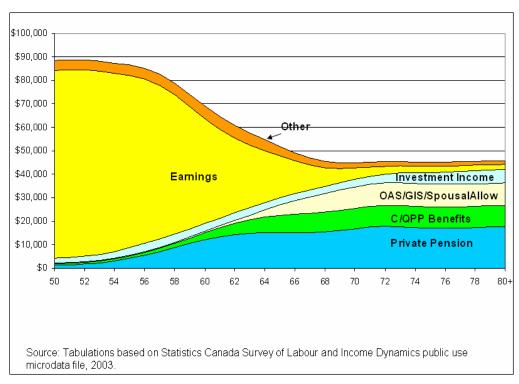


Figure 5.2 - Sources of Income: Male-Headed Households, by Age, Canada, 2003

Source: Byron G Spencer, "Retirement Income and the Public-Private Balance: Lurking Dangers", Prepared for Presentation at the 2006 Queen's International Institute on Social Policy, Queen's University, August 21-23, 2006.

The Committee's interest in this issue is linked closely to its emphasis on choice, addressed in greater detail below.

The Committee also heard about the particular impact on women of historically lower wages and the residual effects of time out of the labour market for unpaid care-giving of children, parents, and other relatives. Dr. Kathleen Lahey emphasized this point:

With lower incomes, lower savings capacities, lower Canada Pension Plan contribution capacity — in terms of insurable hours, insurable earnings and the amount of pension plan that is available — women hit their 50s with a much smaller asset base than men do.

Evidence, April 14, 2008

5.4.1 The Choice to Continue Earning

Beyond CPP and tax regulations with respect to private pension income, seniors' choice to continue to work has been relatively unencumbered by policy or public program design, particularly with the end of mandatory retirement in all provincial and territorial jurisdictions. Witnesses told the Committee that there is no rationale for departure from the labour force at any particular age, especially one as young as 65. Peter Hicks of Human Resources Canada, told the Committee:

Nothing in our biology says we should retire at age 65. There probably was something at the beginning of the last century for manual workers: people in construction and on machine lines. They could not work much beyond 65 in most cases but that rationale has largely disappeared. Similarly, on the social side, there is no obvious reason why we should leave one of the main institutions that gives meaning to our society at age 65. Some people leave for sickness and various reasons but nothing in our society or biology dictates that we must leave at age 65.

Evidence, December 4, 2006

The Committee heard, however, that considerations based largely on economic analysis and more human characteristics can impinge on this choice.

Economists have debated whether older workers are more or less productive as they age, with some arguing that health and memory can deteriorate, and others insisting that corporate memory and skills can increase over time. As noted in Chapter 1, evidence suggests that the vast majority of people retire before their abilities impinge on their ability to work. In a time of labour shortages, however, there is almost universal support for encouraging older workers to stay in the labour market.

For example, the Calgary Chamber of Commerce said the following in a brief submitted to the federal Task Force on Older Workers:

Older workers represent a significant source of underutilized talent and labour supply in the Canadian economy. However, federal government retirement programs and policies such as the Canadian Pension Plan, Old Age Security program, and tax-assisted private savings policies, do not reflect the current demographic, retirement and life expectancy realities in Canada. In fact, these programs may actually deter older worker participation, when they could be modified to create incentives to continue in the labour force. 116

Witnesses told the Committee that low-income workers often experienced an increase in their income when they stopped working

and collected benefits from CPP and OAS/GIS to which they were entitled. Until very recently, low-income seniors receipt of GIS benefits had compelling reason to not offer their skills on the labour market, as 50 cents of every dollar earned was deducted from their **GIS** payment. Budaet 2008 changed that regulation, making the first \$3500 of earnings exempt from this reduction in benefits, thus expanding the choices available to low-income seniors.

The Committee urges the federal government to launch an awareness campaign on the changes to seniors' income programs contained in recent budgets, including the \$3500 exemption from GIS claw-back, legislative changes that removed barriers to phased retirement, and the impact of the new savings plan.

The Committee welcomes this change, and wishes to ensure that low-income seniors are aware of this and other recent developments. Therefore, the Committee urges the federal government to launch an awareness campaign on the changes to seniors' income programs contained in recent budgets, including the \$3500 exemption from GIS claw-back, legislative changes that removed barriers to phased retirement, and the impact of the new savings plan.

¹¹⁶ Calgary Chamber of Commerce, "Older Workers: Amending Federal Government Retirement Programs to Tap Into an Underutilized Pool of Labour Supply", Submission to Federal Expert Panel on Older Workers, July 30, 2007, p. 2.

5.4.2 The Lack of Choice to Continue Earning

The Committee heard that seniors are subject to prejudices about seniors and their abilities (as discussed in more detail in Chapter 1 of this report), particularly with respect to older workers who have been laid off in a company-wide reduction in workforce or who find they are unable to continue in very physically demanding jobs. They are often unable to find employment in similar industries and often cannot find appropriate and effective retraining opportunities. The Committee also heard that older unemployed workers are often lacking the education and skills needed to fill existing vacancies in the labour market.

The Committee heard that requirements for care-giving or health issues are causes for a significant proportion of involuntary departures from paid work. Kevin Milligan of the University of British Colombia told the Committee:

... it is important to keep in mind that not everyone has a choice. About 25 percent of people who retire in those age ranges retire because of health reasons. Another 10 percent retire to care for a family member. Those people do not necessarily have a choice and, therefore, you want to make sure you design a system that treats those people fairly.

Evidence, April 14, 2008

While the Committee heard some testimony on these issues, they were the exclusive focus of the Task Force on Older Workers, chaired by retired Senator Erminie Cohen and appointed by the Minister of Human Resources and Social Development. A review of the briefs submitted to the Task Force reinforced testimony heard before our Committee and provided more detailed information and proposals.

Witnesses and briefs to this Committee and the Task Force have proposed solutions including: greater training opportunities for older workers, financed, perhaps, from Employment Insurance (EI) funds and targeted to older workers; increases in the Working Income Tax

The report of the Task Force on Older Workers *Supporting and Engaging Older Workers in the New Economy* is available on-line at http://www.hrsdc.gc.ca/en/publications resources/Imp/eow/2008/page00.shtml.

Benefit; greater flexibility, perhaps encouraged through changes to provincial and territorial labour standards to allow older workers to continue working on a part-time basis; wage subsidies to employers; and extended benefits under the EI program to serve as a transition to receipt of other income sources, including CPP benefits.

The Committee wants to draw particular attention to barriers created by ageism. Judy Cutler of the Canadian Association for the Fifty-Plus, CARP, told the Committee:

... even where mandatory retirement has ended, older workers still face the challenges of ageist employers who discriminate against those who are as young as 45 when it comes to hiring practices.

Evidence, December 11, 2006

The Committee is conscious that such discrimination violates human rights legislation across Canada and provisions of international

human rights instruments that Canada has endorsed, and could undermine the future competitiveness of the country. Therefore, the Committee the federal urges government to undertake both an awareness campaign against discrimination against older workers and more aggressive scrutiny of the treatment of older workers to ensure

The Committee urges the federal government to undertake both an awareness campaign against discrimination against older workers and more aggressive scrutiny of the treatment of older workers to ensure compliance with existing legislation and regulations.

compliance with existing legislation and regulations.

5.5 The Income Security System

While we have focussed thus far on particular components of the income that seniors rely on, the Committee has heard from witnesses that some of the issues contributing to poverty have to do with the entire system of income sources and their interaction.

5.5.1 Adequacy

For example, the Committee heard repeatedly about the inadequacy of income available to seniors, particularly women and men living alone, demonstrated in the chart below.¹¹⁸

Even where the combined OAS/GIS benefit is equal to Statistics Canada's low income cut-off (LICO), seniors can be vulnerable to any unanticipated expense or emergency.

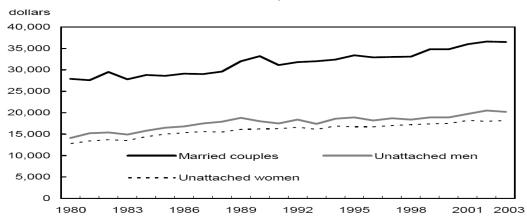


Figure 5.3- Median after-tax income received by elderly families and unattached individuals, 1983 to 2003

Sources: Statistics Canada, Survey of Consumer Finances; Survey of Labour and Income Dynamics.

In addition, several witnesses have described the complexity of the income security programs, and their interaction, and how that can contribute to the failure of seniors to receive the benefits to which they are entitled, as discussed above, and to their poverty. In a brief to the Committee, the Assembly of First Nations recommended:

A detailed analysis should be undertaken of financial support programs for First Nations seniors including American pension plans and RRSP, and a practical, easy to understand manual or toolkit be produced for the use of First Nations staff and seniors when applying for OAS, GIS and CPP. These documents should explain eligibility and why an individual may not be eligible for certain benefits. Training materials and supports [should] be developed and delivered to First Nations service providers to enable

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¹¹⁸ Martin Turcotte and Grant Schellenberg, *A Portrait of Seniors in Canada – 2006*, Statistics Canada, 2007, p. 64.

them to assist seniors in applying for, and receiving these benefits. 119

While some witnesses called for an increase in GIS, endorsed by this Committee, others suggested that a combination of programs would need to be changed. For example, Jean-Guy Saint-Gelais of the Conférence des Tables régionales de concertation des aînés du Québec told the Committee:

... the government needs to ensure that the sum of each senior's benefits, including income security and federal, provincial and private pension payments, place him or her at least over the poverty threshold, as defined by the Government of Canada. That is not currently the case.

Evidence, June 4, 2007

Another witness described the need to coordinate the benefits payable to seniors who are also veterans.

Recognizing the complexity of the interactions among income security programs and the need to ensure adequate incomes for seniors, the Committee recommends:

22. That the federal government look more closely at the question of a Guaranteed Annual Income for all Canadians.

5.5.2 Effectiveness

Along the same lines, the Committee has heard of unintended interactions among programs that affect access to services as well as income, particularly across jurisdictions. For example, the Committee heard that receipt of GIS benefits was sometimes a criterion for eligibility or a trigger for receipt of services delivered by provincial governments, as it is used as a proxy for low-income status.

The Committee also learned of situations in which benefits from some federal income sources would be deducted from provincial

Assembly of First Nations, "Sustaining the Caregiving Cycle: First Nations People and Aging", Submission to Special Senate Committee on Aging, May 2007, p. 19.

supplementary benefits for seniors or that receipt of increased benefits could result in loss of provincially funded services. Therefore, the Committee reiterates that the federal and provincial/territorial governments work to ensure that increases in OAS and/or GIS do not result in loss of eligibility for subsidies or services for seniors.

There was also a common theme raised by witnesses as to the rapid demographic changes and their interaction with a rapidly changing labour market and economy. Therefore, the Committee

The Committee urges that federal, provincial and territorial governments, business organizations, and unions convene to discuss changes in labour force participation and related changes in income security for seniors.

urges the federal government to analyze impacts of increasingly heterogeneous entries into paid work on anticipated retirement income security programs.

Several witnesses also described the need for greater intergovernmental and intersectoral collaboration and planning to ensure continuing income security for seniors, in the same way that this collaboration has been important in areas

like housing and healthy aging strategies. Bob Baldwin a Senior Associate of Informetrica told the Committee:

If there is going to be any collaborative effort, governments can create forums where they bring together people from business and labour to talk about the issues of workplace change and how to make workplaces more appealing for older workers. I know the labour program made a small initiative in this regard a few years back, but I do not believe there was any follow-up to it.

I think it is important to realize government cannot do it alone. If you are going to get a collaborative effort, I think government is probably going to have to take a leadership role.

Evidence, April 14, 2008

Therefore the Committee urges that federal, provincial and territorial governments, business organizations, and unions convene to discuss changes in labour force participation and related changes in income security for seniors.

5.5.3 Assets and Income

Statistics Canada has reported that an increasing proportion of seniors' assets are in their homes, and that an increasing proportion of seniors are home-owners. Witnesses told the Committee that this can lead to the anomaly of seniors having considerable wealth that does not provide income. In addition to contributing to cash poverty, this situation can put pressure on seniors to sell their homes, which runs counter to their preference to age in place.

The Committee heard testimony about the British Columbia property tax deferment program which allows residents to defer their

property taxes with a moderate rate of interest. The provincial government pays the tax to the municipality, and the amount deferred is repaid on sale or transfer of the home. Other provincial and local governments have similar property tax deferral programs, some of which are interest-free, but municipalities

The Committee urges the federal government to explore options for other forms of income streams from equity in owned homes.

reduce their revenues, rather than have them reimbursed by a provincial program. 121

Therefore, the Committee urges the federal government to explore options for other forms of income streams from equity in owned homes.

¹²⁰ Cliff Boldt, Director, B.C. Retired Teachers' Association, Evidence, June 5, 2008.

¹²¹ Prince Edward Island has a provincial program, while Calgary and Ottawa are among cities that offer tax deferral to low-income seniors.

Chapter 6: Supporting Caregivers

The care provided by friends and family members is a cornerstone of our communities and health care systems. As people age and deal with various health conditions, many require assistance

with housework, personal chores, or health-related care. For some, this caregiver role is filled by a spouse, a family member, or a friend. The support provided by caregivers can range from a few hours a week to round-the-clock care. Informal caregivers are a vital part of the health care system, both for seniors at home and in institutional care. They provide about 80 percent of all home care to seniors living in the community and up to 30 percent of services to seniors living in institutions. 122

The 2007 General Social Survey found that, among the population over age 45, 19 percent of men and 22 percent of women assist a senior because of the senior's long-term health condition. Like other Canadians, seniors find themselves both providing and receiving care.

With unpaid caregivers providing 70 percent of necessary care to older, chronically ill and disabled Canadians, there is an urgent need for greater recognition and awareness of the diversity of the caregiving experience...

Palmier Stevenson-Young, President, Canadian Caregiver Coalition

The 2007 General Social Survey found that 1 in 4 of those providing care were over age 65 themselves. Women bear a disproportionate share of the informal caregiving work. While roughly equal numbers of men and women aged 45 to 65 are involved in informal caregiving, women are more likely to be high intensity caregivers.

Not all groups of seniors can turn to family and friends for support. For example, the Committee has heard that many young people in rural and remote communities have gone to urban centres, leaving seniors looking after seniors. Statistics Canada's 2007 General Social Survey reports that roughly one-third of all caregivers were friends (14%), extended family (11%), and neighbours (5%). Future cohorts of seniors may be more likely to have fewer people to rely on.

National Advisory Council on Aging, 1999 and Beyond, Challenges of an Aging Canadian Society, Ottawa, 1999, p. 40.

Statistical projections provided by Dr. Janice Keefe of the Nova Scotia Centre on Aging indicate that while 15 percent of women over the age of 65 did not have a surviving child in 2001, this proportion is likely to increase to 30 percent by 2051. Similarly, the Committee has heard that marriage and divorce trends may imply that, in the future, fewer disabled seniors will have a spouse who could care for them. Given these projections, witnesses have cautioned against placing too great a reliance on informal caregivers at the expense of formal caregiving mechanisms, such as home care.

Formal caregiving options, such as homecare and home support services, are also key to making sure that those providing care are doing so by choice, and not because there are no viable alternatives. There are times when people are unable to provide the required levels of care to their friends or family, either because they have other caregiving responsibilities, are unable to take leave from paid employment, or do not feel competent to provide the care. Those who do provide care need support to deal with the physical, mental, emotional and financial challenges of being a caregiver. Robert Dobie of the National Advisory Council on Aging reminded the Committee that:

The added responsibility of informal caregiving can lead to physical and mental exhaustion and have a detrimental effect on the health of caregivers. Lack of formal supports can lead to burn out, causing caregivers to withdraw from caregiving. This, in turn, can lead to higher rates of institutionalization for seniors.

Evidence, November 27, 2006.

The consequences of ignoring the needs of caregivers are significant for the caregiver, the person receiving care, and the health care system.

6.1 Policy Supports to Help Caregivers

Janice Keefe of the Nova Scotia Centre on Aging¹²³ identified four types of policy supports available to help caregivers:

- direct service to caregivers which gives caregivers respite, support through the home care program, education, information, resources and counselling;
- direct payment, where caregivers receive allowances, compensation or reimbursement for expenses;
- labour policy, where we look at workplace policies, labour standards and Employment Insurance policies such as our compassionate care benefit; and
- indirect compensations tax credits, pension credits, and dropouts from pension.

Canada has made some progress over the past decade towards implementing policies to support caregivers. The 2003 First Ministers' Accord on Health Care Renewal provides for short-term acute home care coverage, and the Employment Insurance compassionate care benefits provide income support iob protection for workers caring for gravely ill members in their final days. 124 But there is still much work to do to support this largely invisible work.

Caregivers experience high levels of stress. If we do not support them, we may end up with two users of our health care system.

Janice M. Keefe, Nova Scotia Centre on Aging, Mount Saint Vincent University

6.1.1 Direct service to caregivers

Caregivers need support in the day-to-day activities of providing care. This can include respite services, additional help through the formal home care program, education, information, resources and counseling. Caregivers also need systems navigators to help them find their way through complex health and social services systems. Currently, the availability and accessibility of these services vary widely across the country.

Palmier Stevenson-Young, President, Canadian Caregiver Coalition, Evidence, June 11, 2007.

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¹²³ Janice M. Keefe, Canada Research Chair in Aging and Caregiving Policy, Nova Scotia Centre on Aging, Mount Saint Vincent University, *Evidence*, July 11, 2007.

Ready Access to Information for Caregivers

The East Kootenay senior caregiver network supports family caregivers over a large mostly rural area of the province, which includes six main communities and many smaller ones. Services include information and support to caregivers delivered through regular local group meetings, a buddy system, a newsletter and a toll free telephone line. Too often caregivers do not know where to go for help; this network empowers them to seek and find the assistance and support they need.¹²⁵

Respite services provide a break for the caregiver, and include a range of services such as adult day care, in-home respite care, overnight or longer-term respite stays in facilities or a mixture of services. ¹²⁶ In its second interim report, this Committee proposed the

As caregivers of loved ones with dementia, husbands suddenly find themselves cooking, cleaning, doing laundry, shopping. Wives find themselves calling plumbers, looking after the finances and doing the driving. Simply, it is overwhelming mentally and physically. Respite allows us to recharge.

Betty Brousse, Volunteer, Alzheimer Society of Canada creation of a National Respite Program. While this option was well received, caregivers who appeared before the Committee emphasized the importance of flexibility in such a program and the need to avoid complicated admission criteria. Caregivers have many different needs which would not fit in a one-size-fits-all model. For example, Sharon Baxter, Executive Director of the Canadian Hospice Palliative Care Association, told the Committee that:

... at the very end of life, families and friends do not necessarily always want time away, but want the ability to spend more time with their dying family member without the constant pulls of the regular duties of life. A national respite program would need to be flexible to

allow for the various types of supportive measures needed during the disease trajectory. Programs such as Meals on Wheels could be considered a type of respite program, and these programs are not always terribly costly.

Evidence, April 7, 2008

Keefe, Janice & Marlie Manning, *The cost effectiveness of respite: A literature review.* Health Canada, Ottawa, 2005.

Elsie Gerdes, BC Old Age Pensioners Organization, Response to Questionnaire from the Special Senate Committee on Aging.

While many provinces have a respite care component in their home care programs, the availability and accessibility of these services vary widely. Unlike Canada, Australia has had a National Respite for Carers Program in place for over a decade. Carer Respite Centres in that country provide advice about respite services, coordinate access to respite services at the local level and can arrange 24 hour emergency respite care. A national Web site contains contact information for local services as well as a 1-800 phone number for information. This stands in stark contrast to the situations in many places across Canada where caregivers have limited support to help them identify and meet their needs.

Caregivers also require information at a time when they have the least time available to look for that information. Witnesses emphasized the important role voluntary sector organizations play in helping individuals navigate through complex eligibility criteria. The Alzheimer Society, for example, helps seniors with Alzheimer's, their families and caregivers anticipate the evolution of the disease and to be better prepared and supported.

First Link

Ontario currently has a pilot project called First Link. It deals only with Alzheimer's and dementia. The First Link coordinator meets with the family health teams and other doctors in a broad community in Southeastern Ontario. She will be given the names of the people who have been diagnosed with dementia. As coordinator, her job is to contact the person and ask if there is any help that they require now or any resources that they think they might need.

Palmier Stevenson-Young, President, Canadian Caregiver Coalition, Evidence, June 11, 2007

Caregivers are also looking for information on how they can serve as effective advocates for those they support, as Judith Wahl of the Advocacy Centre for the Elderly reminded the Committee: It is not just the eligibility, what you get and how you apply and what forms you fill out, but how to navigate through the system and what you do when things go wrong or when you hit a barrier. People need that education and information, and often that provides a relief for them, because they know what to do, what to expect and what the limits are on different things.

Evidence, May 28, 2007

Respite services and access to information and education on caregiving should form significant components of a national caregiver strategy.

6.1.2 Financial support for caregivers

Internationally, informal care accounts for an estimated 75 percent of all personal care provided to seniors in industrialized countries, whether or not they have universal healthcare. Several witnesses have reminded the Committee that Canada lags behind countries such as the United Kingdom, Australia, Germany, Japan, the Netherlands and the United States in providing supports for caregivers. A review of how caregivers are supported in other countries can provide useful examples for Canada to follow.

Governments around the world have developed various compensation policies for caregivers. These include direct compensation in the form of wage, salary or allowance paid to the care receiver or caregivers, and indirect or non-direct benefits in the form of tax relief or third party payment of pensions credits or insurance premiums.

Germany offers universal long term care insurance coverage which allows caregivers to register as employees. This provides them with rights and recognition, including a cash allowance that can be used by the care receiver to compensate caregivers for their services, respite coverage without financial hardship and contributions to statutory pension insurance. The level of pension contribution is

Marcus Hollander et al., "Providing Care and Support for an Aging Population: Briefing Notes on Key Policy Issues," *Healthcare Quarterly*, Vol. 11, No. 3, 2007, pp. 34-45 (p. 42).

contingent upon the level of dependency of the care receiver and the amount of time spent caring. 128

In the Netherlands a care receiver is given a budget based on an assessment of his or her needs. With this personal budget, a care receiver can arrange for services through an organization or can employ an individual, including family and informal caregivers, to provide care. The caregiver can deduct medical expenses and other extraordinary expenditures in relation to the care receiver where these expenses exceed 11.2 percent of income. In addition, the employed caregiver receives 10 days care leave per year. The employer pays 70 percent of wages and the government compensates the employer.

Sweden offers direct payment options, pensions credit accrual and a comprehensive paid leave policy. Two direct compensation programs target seniors' long term care needs – the Attendant Allowance and the Carers' Allowance. The Attendance Allowance is an untaxed payment that goes to the care receiver to be used to pay the family caregiver. The maximum payment is CA\$860/per month, but payment amounts vary by municipality. The Carers' Allowance ensures that the caregivers' salary is equal to that of a formal home help service provider employed by the municipality. This compensatory scheme recognizes the value of the caregivers' time and effort. Caregivers who receive a Carer's Allowance or Care Leave are entitled to pension credits.

The United Kingdom (UK) has a National Strategy for Carers. The UK's *National Health Service and Community Care Act* of 1990 was the "first legislation to formally acknowledge the need to support family caregivers." In 2000, England and Wales passed the Carers and Disabled Children Act, "giving local councils the power to supply certain services directly to caregivers." The Carer's Allowance is an income tested program that targets caregivers of a disabled child or adult. The caregiver receives a taxable allowance of CA\$108 per week which can continue for up to 12 weeks if the caregiver goes into respite care or if the care receiver is hospitalized. This helps provide

Janice Keefe, Pamela Fancey and Sheri White, Consultation on Financial Compensation Initiatives for Family Caregivers of Dependent Adults, Final Report, Mount Saint Vincent University, March 2005, p. 6 and Janice Keefe, "Policy Profile for Compensating Family Caregivers. Germany," October 2004.

Janice Keefe, "Policy Profile for Compensating Family Caregivers, United Kingdom," October 2004.

stability to caregivers help them weather temporary changes in their caregiving situation. A means-tested top-up is available to eligible carers. A pension for carers "targets caregivers whose labour force participation may be impacted by caregiving resulting in longer term consequences."¹³⁰

In Canada, the federal government currently uses tax deductions and reimbursable tax credits to help families offset the costs of caregiving at home. Employed Canadians who take time away from work to care for a family member who is gravely ill with a significant risk of death are entitled to Compassionate Care Benefits under the Employment Insurance Program.

The Committee has heard, however, that these programs are not sufficient to meet the needs of people providing care to their family members and friends. Neena Chappell, Canada Research Chair in Social Gerontology at the University of Victoria, told the Committee that "one thing you hear a lot from caregivers and volunteers is that even to have their out-of-pocket expenses reimbursed, if not their time and labour, would go a long way."¹³¹

The question of financial support to caregivers is another essential component of a National Caregiver Strategy.

6.1.3 Changes to labour policies to support caregivers

Workplace policies and labour standards can help caregivers balance their paid work and caregiving needs. Changes can be made to the *Canada Labour Code* and the provincial labour standards to expand entitlements to paid leave days. Although individual workplace policies are outside of the public purview, the federal government, as the largest employer in Canada, can lead the way in providing flexible leave to allow people to provide care. And finally, the Compassionate Care Benefit can be improved upon to better meet the needs of caregivers and those for whom they care.

¹³¹ Neena L. Chappell, Canada Research Chair in Social Gerontology and Professor of Sociology, Centre on Aging, University of Victoria, *Evidence*, March 19, 2007.

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¹³⁰ Janice Keefe, Pamela Fancey and Sheri White, *Consultation on financial compensation initiatives for family caregivers of dependent adults, Final Report*, Mount Saint Vincent University, March 2005, p. 8.

Employees depend labour on legislation to ensure they have basic employment standards, rights and benefits. Witnesses have suggested that the government of Canada can take a lead, under the Canada Labour Code, to standards which facilitate introduce work-life balance and help caregivers meet their caregiving obligations. addition, the Committee urges the

The Committee urges the federal government, as the largest employer in Canada, to take the lead in the provision of family leave to its employees. This leave should permit the highest level of flexibility in recognition of the diverse forms of relationship responsibilities.

federal government, as the largest employer in Canada, to take the lead in the provision of family leave to its employees. This leave should permit the highest level of flexibility in recognition of the diverse forms of relationship responsibilities.

Compassionate Care Benefits were introduced within the Employment Insurance (EI) program in 2004 to compensate persons who have to be away from work temporarily to provide care or support to a family member who is gravely ill. Regulatory changes introduced in 2006 broadened eligibility to the program so that the benefit can be claimed by a brother, sister, grandparent, grandchild, in-law, aunt, uncle, niece, nephew, foster parent, ward, guardian, or someone considered to be like a family member of a gravely ill person. The Committee applauds this change.

Witnesses have identified a number of suggestions to make the Compassionate Care Benefit even more responsive to the needs of

working Canadians, including the elimination of the two-week waiting period before receiving benefits, increasing the benefit to cover a greater proportion of income and extending the length of the benefit.

The Committee urges government to be more effective in publicizing the Compassionate Care benefits and available tax credits for caregivers.

Witnesses have also suggested that families may not be aware that the benefit exists. Sharon Baxter of the Canadian Association told the Committee:

Hospice Palliative Care

I was in New Brunswick giving a talk about two months ago in a room of almost 100 people, and two thirds of them had never heard of the compassionate leave program. I was stunned. We need to do a better job of marketing.

Evidence, June 18, 2007

The Committee urges government to be more effective in publicizing the Compassionate Care benefits and available tax credits for caregivers.

In the same way that people can drop out for child care, they should be able to drop out for elder care and not be penalized for having done so, and even to have some incentive.

Gloria Gutman, Professor, Gerontology, Simon Fraser University The Compassionate Care Benefit is delivered under the Employment Insurance Program. As is the case with other special benefits under that program, applicants to the program must serve a 2-week unpaid waiting period before EI benefits begin to be paid. Witnesses have suggested that imposes undue hardship to families at a time when they most need support.

The level of income replacement under the Compassionate Care Benefit is set at 55

percent of an individual's average insured earnings, to a maximum payment of \$435 per week. Other jurisdictions provide much more generous coverage. In Sweden, for example, the level of payment is 80 percent of the income. The Committee has heard that while California's program provides a comparable level of replacement as Canada's program, the maximum level of benefit in California is about \$800 Canadian per week, much higher than the maximum in Canada. 133 Witnesses suggested that the level of income replacement under the Compassionate Care Benefit needed to be increased.

Other witnesses felt that the length of the Compassionate Care Benefit, currently 6 weeks, should be extended, and that Canadians be allowed to access the benefit during times of medical crisis, and not only during the palliative stages of illness.

¹³² If compassionate care benefits are being shared by family members, only the first family member claiming these benefits will serve the waiting period.

¹³³ Janice M. Keefe, Canada Research Chair in Aging and Caregiving Policy and Director, Nova Scotia Centre on Aging, Mount Saint Vincent University, as an individual, *Evidence*, June 11, 2007.

As a result, the Committee recommends:

23. That the Employment Insurance Act be amended to:

- Eliminate the two-week waiting period before receipt of the compassionate care benefit;
- Increase the compassionate care benefit to 75 (seventy-five) percent of the earnings of workers;
- Increase the length of the benefit from 6 to 13 weeks; and
- Provide access to the benefit during times of medical crisis, and not only during the palliative stages of illness.

Furthermore, the federal government must promote awareness of the compassionate care benefit among all Canadians.

6.1.4 Indirect compensation for caregivers

Public pension systems in countries of the Western world were initially designed for individuals working full time for an uninterrupted period of time. As women entered the labour force in increasing numbers, however, public pension programs have had to take into consideration periods when people drop out of the labour force to provide care. Because women are more likely than men to reduce their labour force activity (either temporarily or permanently) to care for children and other family members, measures to formally recognize periods of reduced labour force participation due to caregiving can help reduce the income gap between men and women at the time of retirement.

Although the participation of women in the labour force has increased substantially in recent decades, women are still more likely today to have part-time jobs or to put their careers on hold in order to provide care within the family. This results in lower income for women throughout their lives, including at the time of retirement.

In Canada, the Child Rearing Provision was incorporated into the Canada Pension Plan (CPP)/ Quebec Pension Plan (QPP) in 1977 to adjust the pension calculation so that workers would not be penalized for reduced income if they reduced their labour force participation to care for children under the age of seven. Some OECD countries have similarly recognized the impact of other caregiving responsibilities on eligibility for public pensions. For example, in some of the countries which provide caregiver allowances (as noted in section 6.1.2), the state also pays pension credits towards the public pension plans of caregivers.

The CPP currently allows an individual to exclude from the calculation of pension benefits the 15 percent of years in which earnings were lowest. This results in higher average earnings and a

The Committee urges the federal government to consider introducing a drop-out provision for caregivers into the Canada Pension Plan.

higher pension. Witnesses have suggested, however, that Canada consider extending the CPP/QPP Child Rearing Provision to other caregivers. Witnesses have suggested that such a measure would also be especially helpful to those who have had less time to

accrue benefits, including women and immigrants. As recommended in section 5.1.2 above, the Committee urges the federal government to consider introducing a drop-out provision for caregivers into the Canada Pension Plan.

6.2 A National Caregiver Strategy

Addressing the needs of caregivers requires a comprehensive, multi-jurisdictional effort which can best be accomplished through the development of a national caregiver strategy. Initiatives which address only one of the policy areas listed in Section 6.1 risk causing more harm to caregivers. For example, the Committee has heard that financial compensation of caregivers may be a double edged sword for women:

On the one hand, cash payments for family carers do recognize and attempt to ameliorate the direct and opportunity costs associated with caregiving and provide some formal recognition of the caregiving role. On the other hand, these programs can entrap women into

caregiving roles by offering financial support in place of other care options. 134

Witnesses have suggested that in order to avoid such negative impacts a combination of payments and services should be developed. In this way carers receive both income maintenance and services in kind.

The federal government can provide leadership on the development of a Canadian caregiver strategy. Together, the federal, provincial, and territorial governments can put in place the components of support which should be available to all people in Canada. Palmier Stevenson-Young of the Canadian Caregiver Coalition summarized some of the components to be integrated into such a strategy:

... to develop and sustain a communications strategy that informs Canadians about caregiving and that values and acknowledges caregivers in all their diversity; to enhance health and social services for the care recipient, the caregiver and their families; to provide remuneration to caregivers; to develop financial support programs; to provide grants, allowances, tax deductions and reimbursable tax credits to offset the costs of caregiving at home; to ensure that case management plans include assessment of caregiver needs; and to provide information and education to support voluntary sector.

Evidence, June 11, 2007

The Committee recommends:

24. That the federal government work collaboratively with the provinces and territories, policy-makers, stakeholders and family caregivers to establish a National Caregiving Strategy. The Strategy should form a part of a larger federal integrated care initiative.

¹³⁴ Janice Keefe and Beth Rajnovich "To Pay or Not to Pay: Examining Underlying Principles in the Debate on Financial Support for Family Caregivers" in *Canadian Journal on Aging* Volume 26, suppl_1 1 / 2007.

Chapter 7: Supporting the Voluntary Sector

7.1 Seniors and the Voluntary Sector

The voluntary sector plays an important role in supporting individuals and communities. Volunteers provide essential services for all age groups, including seniors. Volunteer work also allows society to tap into the skills and knowledge of older Canadians. Seniors benefit

from a strong voluntary sector as both contributors and beneficiaries.

Twelve million Canadians contribute almost 2 billion hours of time as volunteers each year. Deeply concerning is that much comes from the few: 11 percent of Canadians contribute 77 percent of the volunteer hours. A significant proportion of that 11 percent is older adults.

It is important to keep in mind that there are currently different generations of seniors, and that there are significant differences in volunteering among the older and younger groups of seniors. Work done by Volunteer Canada has concluded:

If we do not find ways to engage generations as they move into their senior years to ensure their contributions are maximized, volunteer involvement and in fact our communities are at risk.

Ruth MacKenzie, Volunteer Canada

The post WWII generation set the bar high for volunteer involvement and their readiness to give time, money and energy to countless causes has played a large part in the evolution of Canada's vibrant voluntary sector. To coin a phrase, Baby Boomers are a rather different "kettle of fish." Now on the brink of retirement, they are *potentially* positioned to replicate and augment the Canadian volunteer environment. But this cohort is different than their predecessors. They are more demanding – seeking opportunities for growth and uses of their time that are

new and innovative and looking for interesting and meaningful experiences. 135

Bernie LaRusic, Vice Chairperson of the Group of IX in Nova Scotia, supports this finding:

Asking seniors to come forward to volunteer does not seem to be the big attraction that it was at one time.... The number of volunteers is going down as the need goes up.

Evidence, June 11, 2007

People volunteer for a variety of reasons. Some want to make a contribution to their communities. Others want to use their skills and knowledge, to learn new things, to develop new skills, to be intellectually stimulated or to feel good or needed. As Elaine Gallagher, Director, Centre on Aging, University of Victoria, told the Committee:

Potential older volunteers are hindered most often by health problems, other commitments or full schedules and lack of time. They want the flexibility to go south for a few months or on a cruise if an affordable opportunity arises.

Evidence, April 28, 2008

People who recruit and retain volunteers need to know this information. They need to know what motivates people to get involved, and what encourages them to stay involved. One of the difficulties for voluntary organizations is the lack of resources to properly manage volunteers. Voluntary organizations need support as they face challenges in recruiting, screening, and training volunteers. Some of this support is being provided by organizations such as Volunteer Canada, but many of the smaller voluntary organizations who addressed the Committee did not appear to have the tools to help them recruit and retain volunteers.

Volunteer Canada, Volunteer Connections: New strategies for involving older adults.2001available on-line at http://www.volunteer.ca/volunteer/pdf/OlderAdults-Eng.pdf.

Elaine Gallagher, Director, Centre on Aging, University of Victoria, Evidence, April 28, 2008.

Seniors play a key role in preserving culture, particularly for Aboriginal and minority language groups. The *Association acadienne et francophone des aînées et des aînés du Nouveau-Brunswick* told the Committee:

The future of francophone minority communities depends largely on the contribution of volunteerism and the role seniors and retirees can play in it. Francophone minority communities are aging. Consequently, it is important that seniors and retirees be able to provide the leadership needed to pass on their language and culture and help develop community vitality.

Evidence, May 13, 2008

In addition to being significant contributors to the voluntary sector, seniors are also often beneficiaries of activities and services

provided by volunteers. Ensuring that this sector remains healthy in the future is an important investment.

The Committee has heard that facilitating volunteerism in the senior years appears to be intricately linked to facilitating volunteerism throughout the life-cycle. As Peter Hicks of Human Resources and Social Development Canada told the Committee, "by and large, people who volunteer when they are older are people who have experienced volunteering when younger." Employers can help their employees adopt and foster

The Committee believes the imminent retirement of the baby-boom generation can be an unprecedented opportunity to recruit new volunteers, but the voluntary sector needs to put in place the right tools to attract and keep these volunteers.

lifelong habits of volunteering. For example, employers could offer time off or flex-time to allow for volunteer activities. The Committee believes that as the largest employer in Canada, the federal government should lead the way in promoting volunteerism among its workforce.

In its second interim report, the Committee outlined options for incentives to encourage people to volunteer. The option of tax credits for volunteerism has initiated much discussion. Some witnesses were

Peter Hicks, Human Resources and Social Development Canada, *Evidence*, February 12, 2007.

concerned that a tax credit would not substantially benefit lower-income Canadians, and that the administrative implications for voluntary organizations would be significant. Others felt that a tax credit for volunteering would send a positive signal about the importance of volunteering. Ruth MacKenzie of Volunteer Canada concluded her comments on a volunteer tax credit as follows:

While it is certainly an interesting and perhaps even attractive proposition, more research is necessary to truly understand the possibility for positive impact and associated risks to volunteer involvement and the culture or philosophy of volunteerism.

Evidence April 28, 2008

Although the reaction to a volunteer tax credit for volunteering

The Committee believes that as the largest employer in Canada, the federal government should lead the way in promoting volunteerism among its workforce.

was mixed, there was strong support across the country for the need to help organizations reimburse volunteers for out-of-pocket expenses. Many non-profit organizations are stretched for dollars and cannot reimburse volunteers for direct expenses. At times, the cost of a bus ticket is a barrier to volunteering for

people. As a result, the Committee recommends:

25. That the federal government work with the voluntary sector to identify mechanisms to recognize and reimburse the out-of-pocket expenses incurred by volunteers, particularly in activities funded through federal grants and contributions.

One of the frustrations for volunteers is the lack of continuity of funding. Witnesses have recommended that governments be encouraged to provide multi-year funding commitments so that volunteers can see continuity in the work they do. Some have suggested that this should apply to the funding for the New Horizons program as well. Ruth MacKenzie, President of Volunteer Canada, told the Committee:

Much of what volunteer involvement is all about is the relationship between the volunteers and where they choose to volunteer or direct their time. Relationships are about faith, reliance, continuity and momentum, concepts

impossible to maintain without knowledge and trust that relationships that are there on March 31 will also be there on April 1, that the beginning of a new year will not mean that programs and people who are relied on might or might not be there.

Evidence, April 28, 2008

Recognizing the value of the voluntary sector in advocating for seniors, in providing seniors with an ongoing ability to contribute their talents to society, and in meeting the needs of the community, including other seniors, the Committee urges the federal government to work with line departments to promote the use of multi-year funding arrangements for voluntary sector organizations.

Seniors organizations play a critical role by relaying information to seniors on many issues. The committee has met with organizations across the country that work with seniors to provide information on important issues such as nutrition, abuse and eligibility for services and programs. Seniors who participate in these organizations are much more likely to be informed.

It is much more difficult to figure out how to communicate with isolated seniors so that they might access the full range of programs and services to which they may be entitled. This is particularly

relevant for immigrant seniors, who also face linguistic and cultural barriers to accessing this information. Such seniors often require person to person contact to navigate the system. As discussed in Chapter 5, outreach challenges continue to result in some people not collecting funding to which they may be entitled, such as Old Age Security and the Guaranteed Income

The Committee urges the federal government to work with line departments to promote the use of multi-year funding arrangements for voluntary sector organizations.

Supplement. It is often front-line voluntary sector organizations, such as Meals on Wheels, which have one-on-one contact with isolated seniors who are so difficult to reach. These organizations play an important role in relaying information to seniors.

The needs of Canadians can be met through a variety of channels, including the family, the private sector, the public sector and

¹³⁸ Eyob Naizghi, MOSAIC, *Evidence*, June 4, 2008.

the voluntary sector. The Committee stresses the importance of understanding the roles that each of these sectors play in providing services to Canadians, including seniors. The voluntary sector cannot replace the public provision of services. The voluntary sector does, however, improve the quality of life of many Canadians. Meeting the needs of voluntary sector organizations will help ensure that these services will continue to be provided in the future. This Committee has only been able to touch the surface of the needs of the voluntary sector. Much more work needs to be done to ensure that this sector remains vibrant. This is why the Committee recommends:

- 26. That the needs of the voluntary sector be the subject of further study, either by a Senate Committee or by an Expert Panel, in order to examine:
 - The emerging challenges of recruiting and retaining volunteers;
 - Options to promote volunteerism; and
 - The role of the federal government in supporting the capacity of the voluntary sector throughout the country, including the use of multi-year funding arrangements and the implications of introducing a tax credit for volunteering.

7.2 New Horizons for Seniors Program

The federal government's New Horizons for Seniors Program provides grants of up to \$25,000 for community projects that encourage seniors to share their skills, experience and wisdom in support of their communities and promote ongoing involvement of seniors in communities to avoid the risk of social isolation. Projects typically focus on themes of contribution to community, active living, social participation and/or partnership building.

The Committee has received positive reviews of that program; however, organizations across the country have identified recommendations which would ensure that the program better meets their needs.

It is of concern to the Committee that Aboriginal Canadians and official language minority groups have both reported that their constituents do not have equitable access to the funding. Given the success of the New Horizons for Seniors Program, the Committee department of the Resources and Social Development to provincial-level that the ensure evaluation committees for the New

The Committee urges the department of Human Resources and Social Development to ensure that the provincial-level evaluation committees for the New Horizons for Seniors program reflect the diversity of the population.

Horizons for Seniors program reflect the diversity of the population, and most particularly, the official language minority population and the Aboriginal population of the province.

The Committee emphasizes the importance of making the funding through the New Horizons for Seniors Program very accessible to all Canadians. Organizations which may have more limited experience accessing funding from the federal government, such as

groups representing visible minorities, disabilities, persons with Aboriginal people and linguistic minorities require a straightforward application process. Some groups have told the Committee that they find the current application process difficult. As a result, the Committee urges the government to review the application process for the New Horizons Program to ensure that are written in plain the materials language, aboriginal languages and the languages of larger immigrant populations, and that efforts are made

The Committee urges the government to review the application process for the New Horizons Program to ensure that the materials are written in plain language, aboriginal languages and the languages of larger immigrant populations, and that efforts are made to communicate the availability of funding to as many groups as possible.

to communicate the availability of funding to as many groups as possible.

In addition, the Committee emphasizes the importance of ensuring that all groups have adequate time to prepare their applications for funding through the New Horizons for Seniors Program. The Committee strongly emphasizes the importance of providing adequate timing between the announcement of a funding competition and the closing date for receipt of applications.

The Committee suggests the federal government's New Horizons for Seniors Program allow organizations to apply for funding for various phases of a single project.

The Committee has heard that short-term funding makes it difficult for organizations to have continuity in the programs and services they provide. The Committee suggests the federal government's New Horizons for Seniors Program allow organizations to apply for funding for various phases of a single

project, so that they might receive multi-year funding for certain projects.

Chapter 8: The Health and Social Care Workforce

Although the majority of Canada's seniors are in good health, seniors remain the most intensive users of the health care system. In 2003, seniors made up 13 percent of Canada's population, but they accounted for one-third of all hospitalizations, more than half of all hospital stays, ¹³⁹ and 44 percent of health care expenditures overall. ¹⁴⁰

The importance of timely, quality, and accessible health care to seniors' quality of life is significant. The first requirement for Canada to be able to ensure that care is having an adequate supply of appropriately trained health and social care professionals. Already, the health sector is one of the fields with the largest number of occupations showing signs of human resource shortages.

Pressures are particularly acute for physicians, nurses, pharmacists, medical technologists and technicians and assisting occupations in support of health services (such as nurse aides and dental assistants). Growth in demand for those occupations has been strong, due to rising needs associated with population aging, increases in government funding for health care and a high number of retirements of existing workers. On the other hand, supply growth in many of these occupations has been relatively weak.¹⁴¹

This shortage is making working conditions even more challenging for health and social care staff currently in the workforce. Over the course of our hearings, we were continuously impressed with the dedication and excellence of the health and social care professionals we met from all corners of the country. We would be remiss not to applaud their tremendous efforts and echo the sentiments of Lyne England, Chair of the Saanich Peninsula Health Association:

¹³⁹ Statistics Canada, "Health Reports: Seniors Health Care Use" in *The Daily*, February 7, 2006.

¹⁴⁰ Margaret Gillis, Public Health Agency of Canada, *Evidence*, December 4, 2006.

Mario Lapointe *et al.*, "Looking Ahead: A 10-Year Outlook for the Canadian Labour Market (2006-2015)" *Horizons*, Vol. 9, No. 4, December 2007, p. 30.

Health care providers at all levels in Victoria are commended for doing their best under very difficult circumstances. Negotiated contracts have not been honoured, many registered nurses have been replaced by licensed practical nurses and health care workers are choosing to work on a casual basis because of untenable workloads in long-term care. For these and many other reasons, all people working within the health care field should be saluted for their dedication, flexibility, compassion, and caring for those that they tend to daily.

Evidence, June 5, 2008

It is expected that population aging will put even more pressure on this tight labour market, affecting both the number and type of professionals needed to provide care at a time when the growing diversity of the Canadian population requires health and social care workers to have, or have access to, a wider variety of additional skills, knowledge and support.

One of the factors adding to the complexity of service provision is the need to be able to serve citizens in the language of their choice. This includes seniors who are part of Canada's official language minorities (francophones outside of Québec and anglophones in Québec) as well as Aboriginal groups and immigrants.

Accurate communication is essential to the relationship between a care provider and the recipient. Miscommunication can lead to a patient not understanding medical advice or a prescribed treatment, and lead to a considerable reduction in the quality of service.¹⁴²

In the best scenarios, family physicians speaking the first language of the patient can provide services in that language. But where such doctors are unavailable, or when referrals to specialists are involved, patients must often resort to rudimentary language skills, sign language, or family members for interpretation. Involving family members can be sensitive, however, due to the stigma associated with some types of conditions, which patients do not wish others to know about. The Committee heard that there is a lack of interpreting services, and even when these are available, they are not used, as Dr.

¹⁴² Aurèle Boisvert, President, South Eastman Health, *Evidence*, June 2, 2008.

Sharon Koehn, Research Associate at Providence Health Centre's Centre for Healthy Aging, described:

Another thing that we have found is that a lot of professionals, even when they have access to interpreting services, they do not order them. They can, through provincial language services, in a lot of cases order an interpreter, but they do not, because of the time that it takes. They would rather make do and get an unsatisfactory or incomplete response from the patient than take the time, because they are not paid for that time. It is the way that the fee for services is structured a lot of time.

Evidence, June 4, 2008

In addition to language differences, these seniors and their families or other immediate social support networks may have cultural or religious practices which affect that care. We must understand that an individual's aging occurs in a community where language and culture are primordial. 143

This is especially true in Aboriginal communities, where seniors face a range of barriers to accessing care. Confronted with a medical system that does not reflect who they are as cultural beings diminishes access and the quality of care. Competency for health service providers working with First Nations, Inuit and Métis should include understanding language and cultural traditions, the impacts of residential schools, and the importance of family in the life of the elder.¹⁴⁴

The Committee heard that medical and nursing schools are moving towards cultural competency training, but that this movement is slow. 145

In this context, the Committee endorses the statement by Jean Balcaen, President of Villa Youville:

¹⁴³ Charles Gagné, Director General, Centre Taché and Foyer Valade, *Evidence*, June 2, 2008.

Joe Gallagher, Senior Director, First Nations Health Council, *Evidence*, June 4, 2008.

Dr. Sharon Koehn, Research Associate, Centre for Health Aging, *Evidence*, June 4, 2008.

It is therefore very important to continue maintaining a level of health care that is respectful of the beneficiary's linguistic and cultural reality. Awareness of the importance of ongoing attention to cultural differences is closely linked to the quality of patient care.

Evidence, June 2, 2008

The federal government's role with respect to these groups is discussed further in Chapter 10.

8.1 Increasing the Supply of Trained Gerontologists and Geriatricians

Generally speaking, there are two types of physicians whose practice focuses on seniors and especially frail seniors:

- Family physicians who have completed a 6-month or one-year enhanced skills training program called the Care of the Elderly, accredited by the College of Family Physicians of Canada.
- Specialists in geriatric medicine (geriatricians) who have completed a minimum of five years post-graduate training. 146

Early in its hearings, the Committee heard evidence about the current shortage of geriatric specialists. Although the number of geriatricians almost doubled from 111 to 211 between 1995 and 2007, this was still far short of the 538 that were estimated to be needed in 2006. The number of employed nurses whose area of responsibility is geriatric or long-term care has remained relatively stable from 1995 to 2006. The committee heard evidence about the current shortage about the current shortage and the number of geriatric and the current shortage about the c

Dr. Duncan Robertson, Geriatric and Palliative Care, BC Medical Association, Evidence, June 5, 2008, and The College of Family Physicians of Canada, Priorities for the Health Care of the Elderly: The Role of the Family Physician, June 2007.

¹⁴⁷ Canadian Institute for Health Information, *Scott's Medical Database, 2007*, and The College of Family Physicians of Canada, *Priorities for the Health Care of the Elderly: The Role of the Family Physician*, June 2007.

National Advisory Council on Aging, Seniors in Canada 2006 Report Card, 2006, p. 19.

¹⁴⁹ Canadian Institute for Health Information, *Registered Nurses Database*, 2007.

Of the 211 geriatricians, however, the Committee heard that many have other responsibilities, reducing the number of active full-time equivalencies to probably less than 150. Even more alarmingly, the number of internal medicine residents entering geriatric medicine programs has decreased dramatically over the last 10 years. The Canadian Geriatric Society reports that in 2007 there were only five trainees in English-speaking programs for the entire country. Likewise, Care of the Elderly family medicine training programs have many vacancies and there are only 140 physicians with this training in Canada. 151

In contrast to the United States, where many geriatricians are in primary practice, Canadian specialists in geriatric medicine do not provide primary care. They act as a short-term resource to primary care physicians, and health care teams in the community, in hospitals and in long-term care facilities. By functioning as a catalyst within the system, they can set up model services, which others can then manage and disseminate.

Further compounding the challenge of the existing human resource shortage and the anticipated increase in demand is that the current healthcare workforce is itself aging, and recruitment numbers are not keeping pace. The Canadian Association on Gerontology reported to the Committee that the "average age of a registered nurse in this country is close to 50." 152

This highlights the first major challenge mentioned by a number of witnesses: attracting more young people to the field. Geriatric and gerontological specialties seem to suffer from an image problem. Surveys by the University of Western Ontario have found that students prefer to work with patients who are cognitively aware, have single, well-defined problems and are not chronically ill.¹⁵³

 Dr. Chris Frank, President, Canadian Geriatric Society, Brief to the Committee, April 20, 2008.

Dr. Duncan Robertson, Geriatric and Palliative Care, BC Medical Association, *Evidence*, June 5, 2008.

¹⁵² Sandra Hirst, President, Canadian Association on Gerontology, *Evidence*, December 11, 2006.

¹⁵³ Canadian Press, "Canada's Ageing Population Could Run Short on Docs," July 19, 2007.

Witnesses revealed to the Committee that geriatrics and gerontology are often not seen as "sexy", perhaps resulting in part from underlying ageist attitudes in society. Giving people the opportunity to experience the excitement of actually working in the field, to confront the complexity of the problems associated with aging and to see how they are being overcome are ways of helping people see what a stimulating and rewarding field it can be. 154

But promoting geriatrics is even more difficult when most medical schools in Canada do not require any exposure to it. Rotations in geriatric medicine are still not mandatory for Canadian internal medicine training programs, ¹⁵⁵ so students are required to choose a speciality towards the end of their third year of training without ever having had any formal introduction to the field. ¹⁵⁶ This was once the case for palliative care until the Government of Canada supported the development of a medical school course on palliative care. Now, all medical students have at least one course in palliative care. Could we not do the same in geriatrics?

Appealing to the idealistic instincts of medical students may also be another strategy. Dr. Ken Rockwood, Professor of Geriatric Medicine at Dalhousie University, shared his approach for marketing geriatrics to medical students.

So You Want to Save the World?

For years and years we have tried to get more young doctors to do geriatric medicine and one tries various ways to attract them in. One of the things I try when they are still quite young is to say, "If you want to save the world, you should do geriatrics," and here is the way that it works. If we think about all of the problems in healthcare in Canada right now, to my mind, frailty is the one that is most likely to undermine the public provision of medical care because everybody is frustrated, and in not knowing what to do they say, "Well, we will just turn to the private system." That is perverse for reasons that we could go into, but if you think about it, Medicare is one of the great unifying

Dr. David Martell, Lunenburg Medical Centre, as an individual, *Evidence*, May 12, 2008.

David Hogan, "Proceedings and Recommendations of the 2007 Banff Conference on the Future of Geriatrics in Canada" Canadian Journal of Geriatrics, Vol. 10, Issue 4, 2007, pp. 133-144.

¹⁵⁶ Chris MacKnight, Associate Professor, Department of Medicine, Dalhousie University, *Evidence*, May 12, 2008.

themes in Canada. So, if we cannot get this right, what hope is there for the country? With everything that Canada has, if we cannot keep the country in place, what hope is there for the world? So I say to people, "If you want to save the world, do geriatrics in Canada."

Dr. Ken Rockwood, Professor of Geriatric Medicine, Dalhousie University, Evidence, 12 May 2008

Once students are convinced to go into geriatric medicine, there needs to be residency places for them to study, especially in locations where it is hoped they will practice after completing their studies. Because of competition among subspecialties, it seems that this is not always the case. If students can be promised guaranteed training slots and a reasonable prospect of being hired afterwards, the incentives for the field would be much stronger. Therefore, the Committee recommends:

27. That the federal government support education and outreach campaigns promoting geriatric and gerontological health care professions as career choices, including the funding of residency positions in geriatrics.

A second issue discouraging physicians from entering the field is current remuneration practices. The standard fee-for-service billing system financially penalizes geriatricians compared to other specialists because geriatricians tend to take more time with each patient to look at the often multiple issues facing a patient in a more holistic and interdisciplinary way.

Valuing work with seniors means ensuring a competitive salary for the health care professionals serving them. As Réjean Hébert, Dean of the Faculty of Medicine and Health Sciences at the University of Sherbrooke, noted:

Gerontologists do not make as much money as do cardiologists, neurosurgeons or radiologists. I think this discourages students from thinking of a career in gerontology. The same goes for nurses. We must value the care provided by nurses to the elderly by improving

¹⁵⁷ Dr. Ken Rockwood and Dr. Chris MacKnight, *Evidence*, May 12, 2008.

their working conditions and their salaries so that these health care professionals feel the work they are doing is important, and we must provide them with the appropriate training.

Evidence, May 16, 2008

In Canada, alternative funding plans or blended payment models have allowed some geriatricians to find sustainable practice arrangements, but these are certainly not incentives to the field. On

The Committee emphasizes the need for a more equitable billing system for geriatric physicians and suggests the federal government take a leadership role in testing and demonstrating billing systems with the geriatric physicians it employs which might work for other jurisdictions.

the other hand, increasing pay scales has had a notable effect in attracting the needed number of geriatricians in Ireland.

Therefore, the Committee emphasizes the need for a more equitable billing system for geriatric physicians and suggests the federal government take a leadership role in testing and demonstrating billing systems with the geriatric physicians it

employs which might work for other jurisdictions.

Accelerating recognition of immigrants' health care training would also help alleviate the shortage of health care professionals. Top-ups in training or re-accreditation are much more rapid alternatives than beginning the training process with new students.

The Committee urges the federal government to work with professional accreditation bodies to develop programs that will facilitate and accelerate the recognition of foreign credentials.

Movement in this direction could reverse the shrinking proportion of physicians who are foreign trained, which fell from 25 percent of all physicians in 1999 to 22 percent in 2006.¹⁵⁸

Correspondingly, the Committee urges the federal government to work with professional accreditation bodies to

develop programs that will facilitate and accelerate the recognition of foreign credentials.

¹⁵⁸ Canadian Institute for Health Information, Scott's Medical Database, 2007.

8.2 Adapting Training for an Aging Population

A huge need across this country is education of our health care professionals about elder issues.

Dr. Marianne McLennan, Director, Seniors, End of Life and Spiritual Health, Vancouver Island Health Authority, *Evidence*, June 5, 2008

Beyond gerontological and geriatric specialists, the reality is that almost all health professions are dealing with an increasingly aging population. In this context, the Committee agrees with Dr. Duncan Robertson of the BC Medical Association's Geriatrics and Palliative Care Committee who recommended that:

... curriculum content is enhanced for all students and [is] not just didactic, it is a mandatory clinical experience that involves working with older people in the community, in the hospital, in the long-term care facility, in all aspects of care.

Evidence, June 5, 2008

The problems more frequently presented by an aging population have some differences from younger groups. Co-morbidities, chronic conditions and frailty are more frequent – problems that may not be adequately addressed in current curricula. As Byron Spencer, Professor of Economics at McMaster University, described:

... the evidence suggests that training programs for physicians and other health care professionals give little attention to the specific treatment of older patients.... Put differently, the training of health care professionals gives very little time to the treatment of complicated chronic conditions that are common among older patients. Almost all physicians training takes place in a hospital setting and, when older patients present themselves in that setting, the focus is typically on an acute condition. Indeed, it may even be the case that the failure to appropriately treat those who have multiple chronic conditions while they are still functioning in the community can lead to acute symptoms that cause them to present themselves in hospitals.

Evidence, May 5, 2008

Traditionally, the health care system has been based on dealing with one condition at a time. Frailty, however, is the result of multiple interacting medical and social problems. When someone is frail, they do not need the same style of healthcare. 159

The healthcare system's response to complex cases has tended to take the form of inter-professional teams. As the Pan-Canadian Health Human Resource Strategy points out, this approach requires parallel modifications to educational programs:

Changing the way we educate health care providers is key to achieving system change and to ensuring that health care providers have the necessary knowledge and skills to work effectively in interprofessional teams within the evolving health care system. ¹⁶⁰

The social aspects of frailty, not to mention the social aspects of well-being, necessitate an approach based on the empowerment of the individual within her or his broader support network. Training on the ability to enter into dialogue with a broader spectrum of stakeholders becomes more important.¹⁶¹

Similarly, training to help that broader spectrum of stakeholders understand the dynamics of, and their role in, a multi-faceted response is also important. Pamela Fancey, Associate Director of Mount Saint Vincent University's Centre on Aging, indicated to the Committee that there is:

... equal need for gerontology training and education in a wider range of workers and professions including family educators and counsellors, program coordinators, researchers, policy analysts and even supporting budding entrepreneurs.

Evidence, May 12, 2008

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¹⁵⁹ Dr. Ken Rockwood, Professor of Geriatric Medicine, Dalhousie University, *Evidence*, May 12, 2008.

Health Canada. Pan-Canadian Health Human Resource Strategy at http://www.hc-sc.gc.ca/hcs-sss/pubs/system-regime/2006-wait-attente/hhr-rhs/index-eng.php

Marie Beaulieu, Professor, Social Services, University of Sherbrooke, *Evidence*, May 16, 2008.

In order to strengthen and adapt educational programs more broadly in the context of an aging population, the Committee urges the federal government to support capacity building projects, such as the

development of a core program for training in geriatric medicine, gerontological social work, gerontological nursing and other disciplines.

Another significant element of educational programs in the context of an aging population is an awareness of the indicators of abuse and appropriate responses. As mentioned in Chapter 1,

The Committee urges the federal government to support capacity building project, such as the development of a core program for training in geriatric medicine, gerontological social work, gerontological nursing and other disciplines.

the Committee looks forward to the federal government's support for the creation of training materials on this topic for a wide range of professional sectors.

8.3 Training of Home Care and Personal Support Workers

The majority of home care is given by family members and other concerned unpaid caregivers. The Committee heard that fully 90 percent of needs are not met by the public system – needs for which people depend on informal supports such as family and friends. 162

However, with smaller family sizes and an increasingly mobile population separating family members, it is likely that more and more seniors will require external support. Shortened hospital stays in recent years have meant that even more time recovering is spent in the home and community with the assistance of home care. Furthermore, the desire of seniors to remain at home while rates of chronic disease climb in the population will also contribute to the demand for formal home support. Both situations are generally positive, provided there are adequate home care supports in place.

Home care and home support agencies deliver a vast array of services. Susan VanderBent of the Ontario Home Care Association listed some of these services:

Marie Beaulieu, Professor, Social Services, University of Sherbrooke, Evidence, May 16, 2008.

... nursing care, home support services, personal care, physiotherapy, occupational therapy, social work, dietetics, speech language therapy and medical equipment and supplies in the home.

Evidence, May 9, 2008

Personal Support Workers can provide home management (such as shopping, house cleaning and meal preparation), personal care (such as dressing, personal hygiene, mobility and other routine activities of living), family responsibilities (such as routine caregiving

The Committee believes personal support and home care workers deserve greater recognition, training, and support.

to children), and social and recreational activities. 163

Witnesses before the Committee emphasized that home care and home support workers are under-recognized for the work they do, and could play a much

more pro-active role with appropriate training, remuneration and support. As Elaine Gallagher, Director of the University of Victoria Centre on Aging, described it:

These home support workers are an army of the most underutilized health care workers in our country. They are given little to no training for their jobs, they are paid at the very bottom of the pay scale, and they are given no respect for picking up early signs of dementia, frailty and other issues. With a little bit of extra training, they could do a great deal.

Evidence, April 28, 2008

The role of personal support workers is even more critical for seniors at risk. The Ontario Network for Prevention of Elder Abuse emphasized to the Committee that:

Personal support workers (PSW) are one of the largest groups to interact with seniors in their homes and may be the only contact the senior has with the broader community. The close individual care that a PSW provides offers an opportunity to develop a relationship of trust

Personal Support Network of Ontario, http://67.19.94.210/~psw//index.php?option=com_content&task=view&id=16&I_temid=44

with the senior. As a result seniors may first confide in this person about abuse. 164

An example of the potential impacts of enhanced training for home care and home support workers can be found in the SAIL project.

SAIL - Seniors Active in Independent Living

Led by Dr. Vicky Scott at the University of Victoria, SAIL is a training program for home support workers to carry out an assessment of care recipients' risk of falling and, based on the assessment, implement a range of interventions. One intervention is a simple, 10-minute, inhome exercise program which the home support worker leads with the care recipient.

Through the training and the home support worker taking 10 minutes of additional time on each visit, SAIL was able to achieve a 44 percent reduction in the rate of falls compared to homes where workers did not have that training. Economic concerns about the extra time were not an issue for home support agencies, who found the program to be well worth the time. It gave the workers the knowledge, training and information they needed to work with one the highest risk and most difficult populations. People loved the program.

Every health authority in B.C. is now adopting this program and introducing it to their home support workers.

Elaine Gallagher, Director, Centre on Aging, University of Victoria, *Evidence*, April 28, 2008

Despite the key role that home care and home support workers play, jobs tend to offer low wages, less security, and fewer regular hours. As Cecile Cassista, Executive Director of the Coalition for Seniors and Nursing Home Residents' Rights, described:

What happens in New Brunswick, the government contracts out homecare services to agencies and to Red

Ontario Network for the Prevention of Elder Abuse, Response to Senate Interim Report: Issues and Options for an Aging Population, May 9, 2008.

VON Canada, Submission to the Special Senate Committee on Aging, December 17, 2007.

Cross at \$13.64 an hour, so the staff are only getting about \$8 or \$9 an hour and are working 15 to 20 hours a week. We have a retention and training problem in this province.

Evidence, May 13, 2008

Poor working conditions inevitably lead to a high turnover of staff and a lack of continuity in services for care recipients. If we are serious about valuing the services provided by home care and personal support workers, these workers should receive liveable wages, adequate benefits, and good working conditions.

The Committee has heard that the Federal/Provincial/Territorial Health Human Resource Strategy does not include home and community support services despite the fact that the 2004 10-year plan to strengthen health care recognized that home care is an integral part of the health system. A pan-Canadian approach to health human resources must include home care and personal support services. To that end, the Committee recommends:

28. That the federal government work with the provinces and territories to address the training, recruitment and retention of home care and home support workers as part of the FPT Health Human Resource Strategy.

Formal training in the field remains limited. Despite the key role

The Committee emphasizes the need for governments to work with personal support and home care workers to establish common training standards.

personal support workers play, only three provinces - Alberta, Nova Scotia and Ontario - offer diplomas, programs or courses in the field. Best practices learned in these provinces could support the development and implementation of a national training curriculum for home

care and personal support workers. These efforts would have the added benefits of raising awareness of the value of home care and

Congress of National Seniors Organizations, Submission to the Special Senate Committee on Aging – Second Interim Report, Respecting Chapter Five, June 2, 2008.

¹⁶⁷ Ibid.

personal support workers, foster wage parity, and help address recruitment and retention issues.

For those reasons, the Committee emphasizes the need for governments to work with personal support and home care workers to establish common training standards.

Chapter 9: Incorporating Research and New Technology

Canadians are aging in a changing world. The ways that people age change over time – the baby-boomer generation may not have the same needs and expectations as their parents. Technological

advances continue to open up new possibilities.

Policy-makers need to base their decisions on sound evidence and a grounded understanding of the many ways people age. This will require ongoing, longitudinal research to understand the process of aging, and the complex ways that economic, social and health factors affect how people age well. Seizing the opportunity of an aging population will also reauire better understanding of technological advances can be used to improve the quality of life of Canadians and to make the most efficient use of limited human resources.

We are producing important research funded by the federal government, but we need to make better use of it to better serve senior Canadians.

Doug Rapelje, Representative, Senior Citizens Advisory Committee to the City of Welland

9.1 Research on Aging

The Institute of Aging is one of the 13 institutes through which the Canadian Institutes of Health Research (CIHR) funds researchers across the country. The Institute of Aging funds research relating to healthy and successful aging, biomedical and biological mechanisms of aging, cognitive impairment, aging and the maintenance of functional autonomy, and health services and policies relating to older people. In all this research, the Institute of Aging recognizes that translation of findings for seniors and those who work with seniors is very important. The following example of a balance-enhancing shoe insert designed to reduce the risk of falling in older people demonstrates how research can concretely improve the lives of seniors.

New product helps seniors stay on their feet

Falling is a real and dangerous risk for seniors, leading to broken bones and an end to independent living. Dr. Stephen Perry of Wilfrid Laurier University has recently translated his basic research on human movement into a product that may prevent these falls and, in doing so, save many seniors' lives. As we age, we often lose sensation in our feet, making it difficult to stay balanced. With the help of CIHR funding, Dr. Perry and his colleagues have developed a simple and inexpensive special shoe insole called the Sole SensorTM. The insole has a slight ridge along its outer edge that alerts seniors when they are losing their balance. This device promises to reduce the frequency of fall-related injuries.¹⁶⁸

Doug Rapelje, Representative of the Senior Citizens Advisory Committee to the City of Welland and advisory board member to the Institute of Aging, echoed the concerns of several witnesses related to making research more widely accessible:

I am so impressed with the research that is being done, but as a layman I am very concerned about our inability to transfer that important information to the right people so that it brings about change. I suggest to this committee that we look for ways to insist that researchers write summaries that laypersons understand. Research is a language of its own. It is not Canadian. I think that is an important area, because there is wonderful information that never gets used, never gets to the right people.

Evidence, May 9, 2008

The Committee encourages the CIHR to continue to make the translation of knowledge a priority.

The Committee commends the Institute of Aging on its efforts to identify the research needs of seniors and those who work with them and to translate research into useful tools for Canadians. The Committee encourages the CIHR to

continue to make the translation of knowledge a priority.

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¹⁶⁸ Canadian Institutes of Health Research, Aging - Your Health Research Dollars at Work 2006-2007, http://www.cihr-irsc.gc.ca/e/35187.html

9.1.1 Canadian Longitudinal Study on Aging

A team of more than 200 researchers from 26 Canadian universities are working together to develop an innovative, transdisciplinary study on aging, known as the Canadian Longitudinal Study on Aging. Much of what we know about aging is from snapshots and pictures taken at one point in time.

In contrast, the Canadian Longitudinal Study on Aging would track between 30,000 and 50,000 Canadians over the age of 40 to identify the processes and factors that affect health and aging over a twenty year period. Many individuals feel that they can and do age well, even when faced with decline and adverse circumstances. The Canadian Longitudinal Study on Aging would allow decision-makers to "identify the factors that have the greatest impact on successful aging and to better understand how they exert their effects." 169

How can the Canadian Longitudinal Study on Aging have a direct impact on policy?

One of the key ways is by tracking key life-course information and events leading up to the transition from work to retirement and transitions post retirement. As an example, many policies with respect to work and retirement are based on the model of an individual, typically male, holding a job in one organization for a long period of time. However, the reality today is that many people work job to job or engage in periods of unemployment, particularly as they move toward retirement. The rise in the prevalence of women in the paid work force and the increase in the number of dual-income families have also created new issues for balancing work and life demands, as have the growth of non-standard paid work — for example selfemployment, contract work or consulting — and casual employee status — a recent phenomenon that has important implications for forecasting retirement and that has not been well studied. The pending withdrawal of the large baby boom cohort from the workforce also has implications for policies with respect to age at retirement, labour force shortages and the loss of experienced workers.

A more complete understanding of the impact of these changes will allow policy-makers to develop and implement policies with the

Susan Kirkland, Professor, Canadian Longitudinal Study on Aging, Dalhousie University, *Evidence*, February 19, 2007.

greatest opportunity of increasing health and productivity of the labour force.

Susan Kirkland, Professor, Canadian Longitudinal Study On Aging, Dalhousie University, *Evidence*, February 19, 2007

The Committee is pleased to learn that the Canadian Institutes of Health Research recently confirmed a commitment of \$23.5M to support the five-year implementation phase of this twenty-year study. This investment will enable the study to establish itself solidly as a national, longitudinal research and data platform.

9.2 Telemedicine and Telehomecare

Telemedicine is an emerging field which does have the capacity to expand the availability of services or the ease of delivery of services.

Tom Peirce, Senior Director, Strategic Planning and Integration, Hamilton Niagara Haldimand Brant Community Care Access Centre, *Evidence*, May 9, 2008

Telemedicine is the delivery of health-related services and information using telecommunications technologies. ¹⁷⁰ It is most commonly used for the delivery of clinical care, improving

administrative efficiency and expanding education and professional development for healthcare workers.

The Committee believes telemedicine and telehomecare can enhance the delivery of health and home care services.

Telehomecare also uses technology to enhance patient monitoring and selfmanagement. Data gathered at home, by the patient or a healthcare worker, is transmitted and analyzed centrally, facilitating early

detection of changes in vital signs and rapid intervention to prevent deterioration. This approach has been shown to lower health system costs, especially for chronic disease management, by reducing hospitalization rates, emergency department visits and long-term home admissions.¹⁷¹

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¹⁷⁰ Ontario Telemedicine Network, http://www.otn.ca/.

¹⁷¹ Ontario Telemedicine Network, http://exweb.otn.ca/telehomecare/.

Although the technology is rapidly evolving, the value of its potential application to the health and home care sectors has been understood for some time. The April 2002 report of the Standing Senate Committee on Social Affairs, Science and Technology¹⁷² as well as the November 2002 report of the Commission on the Future of Health Care in Canada¹⁷³ both identified telemedicine as a strategy for strengthening the delivery of health services.

The absence of these subjects in our second interim report on Issues and Options for an Aging Population was highlighted by numerous witnesses across the country. The Committee heard from a range of agencies that are evaluating and implementing telemedicine initiatives, such as Dr. Marianne McLennan of the Vancouver Island Health Authority:

We are looking at technology as a way to deal with getting service closer to people and where they live, as well as using in the best way our professionals who may be in South Island for [residents] in the North Island. So we are looking at video-conferencing and telephone transition support groups and we are looking at innovative education approaches to keep our staff up to date on the latest information.

Evidence, June 5, 2008

Telemedicine is also being used to facilitate services to patients in minority language situations, such as francophones in Ontario, as described by Marcel Castonguay of the Community Health Centre Hamilton-Niagara:

We have started to use videoconferencing, where we can give a workshop in Welland with an audience in Hamilton and have an interactive discussion. We are trying to see how we could connect up with other communities where we could have province-wide discussions with a nurse. There again, health care professionals are still very scarce

173 Roy J. Romanow, Building on Values: The Future of Health Care in Canada, Final Report, November 2002.

¹⁷² Standing Senate Committee on Social Affairs, Science and Technology, *The* Health of Canadians - The Federal Role, Volume 5: Principles and Recommendations for Reform – Part I, April 2002,

and difficult to recruit and are not necessarily where the patients are.

Evidence, May 9, 2008

This is one illustration of how the shortage of health human resources can be offset somewhat by an increased use of technology. In addition to extending the services of specialized health care professionals, technology can allow others to simply see more patients in a day. As described by VON Canada:

Home health nurses may provide 20 or more visits per day with the help of technology versus only 4 to 8 inperson visits.

Brief to the Committee, December 17, 2007

Telemedicine and telehomecare can also improve services to seniors in rural areas. Transportation to medical services, notably specialists, often means significant transportation costs for patients in rural areas and is not always readily available. The Committee agrees with the Standing Senate Committee on Agriculture and Forestry's recent report on rural poverty which identifies telehealth as a strategy for addressing the shortage of rural health care providers and the lack of medical and nursing training geared to rural practice settings, improving rural health infrastructure and ensuring a more equitable development of health information systems across the country.¹⁷⁴

In serving rural and remote locations, telemedicine can be especially relevant for First Nations and Inuit communities. But in order for those communities to use many telemedicine applications they must have a high-quality internet connection, which is still not a reality in many communities. As Joe Gallagher of the First Nations Health Council pointed out:

One of the action items in the tripartite health plan that we are working on is to create and implement a fully integrated clinical Telehealth network for First Nations in B.C. ... We have some big challenges in front of us in this whole area of connectivity.

Evidence, June 4, 2008

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Standing Senate Committee on Agriculture and Forestry, Beyond Freefall: Halting Rural Poverty, Ninth Report, June 2008, p. 282.

While technology cannot replace the need for appropriately trained health care professionals, it can allow those professionals to serve more patients, more efficiently. In this light, the Committee recommends:

29. That the federal government support and invest in the expanded use of telemedicine and telehomecare through a transition fund for provinces, a home technology fund for home and community care organizations, and by improving technology use in the direct provision of services to its client groups, including ensuring internet connectivity in northern and remote communities, and that Canada's official-language minority communities be consulted in the development of such an initiative.

9.3 Electronic Health Record

Canada lags way behind in the implementation of the Electronic Health Record, and Canadians are unaware of the difficult decisions that need to be made. Without data and information, it is very difficult for that to be done.

Donald Juzwishin, Health Council of Canada, *Evidence*, April 7, 2008

The electronic health record (EHR) is essential to the needed integration of services described in Section 2, and can bring many efficiencies to our health care system.

As greater users of the health care system, seniors who may be referred to a number of health care providers or require services from different agencies stand to benefit even more from the potential time and cost savings as well as health benefits that would come from avoiding multiple assessments, duplicate tests and harmful drug interactions. Witnesses across the country were clear on this and illustrated how they are working towards the implementation of the EHR.

Accurate, timely information that reduces duplication of tests, misinformation being communicated, has merit, and I believe as much effort as is necessary should be put into it to advance it nationally.

Tom Peirce, Senior Director, Strategic Planning and Integration, Hamilton Niagara Haldemand Brant Community Access Centre, *Evidence*, May 9, 2008

From the perspective of long-term care home operators, ... within our Local Health Integration Network area, a group of 20-some-odd homes have expressed the interest in getting involved in some of the LHIN initiatives to record or have the information available electronically and share it so that seniors tell their story once and not have to repeat it over and over again. More importantly or equally importantly is not to have the system repeat all those tests and all the expenses involved.

Dominic Ventresca, Director of Seniors Services, Regional Municipality of Niagara Community Services Department, *Evidence*, May 9, 2008

We should not duplicate the different assessment of the elderly people and be sure that one assessment is common to all the agencies and that there is good communication between agencies. The electronic health record is a very strong instrument to foster such coordination. It works in a Canadian context. We know how to implement that. We know that there is no extra cost to implement such a system....

Réjean Hébert, Faculty of Medicine and Health Services, University of Sherbrooke, *Evidence*, May 16, 2008

Those investments are significant, but the benefits are even greater. The total cost has been estimated at \$10 billion to \$12 billion, but when fully implemented, the savings are pegged at \$6 billion to \$7 billion annually.¹⁷⁵ Of course, the value of lives saved is immeasurable.

Although efforts are being made, witnesses before the Committee expressed concern that progress on implementing the electronic health record was not advancing fast enough. In Canada, development of the EHR has been led since 2001 by Canada Health

¹⁷⁵ Canada Health Infoway, *Annual Report 2007-2008.*

Infoway, a federally-funded, non-profit organization that oversees the development of Canadian standards while working with provinces and

territories which implement and operate their systems. The Committee emphasises the importance of ensuring that Canada's official-language minority communities are consulted in further development of electronic health records in Canada.

The Committee urges the federal government to provide adequate support for Canada Health Infoway to achieve its long-term objective of electronic health records for Canadians.

Canada Health Infoway's goal is to provide 50 percent of Canadians with an

EHR by 2010. However, the absence of additional funding in the federal government's 2008 budget is putting that objective at risk. Therefore, the Committee urges the federal government to provide adequate support for Canada Health Infoway to achieve its long-term objective of electronic health records for Canadians.

¹⁷⁶ Canada Health Infoway, About Canada Health Infoway – Backgrounder.

Chapter 10: Federal Population Groups – Leading by Example

The people of Canada justifiably expect that the Government of Canada will lead in national efforts to improve the situation for Canadian seniors. While provincial and territorial governments are important champions of seniors in their respective jurisdictions, the Government of Canada has particular responsibilities for several population groups. More specifically, the Government of Canada's distinct roles with regard to seniors include its federal role whereby it has direct jurisdictional responsibilities for certain population groups and its national role where it has indirect responsibility played out in collaboration with provincial and territorial governments.

10.1 Direct Federal Leadership

The Government of Canada's specific federal role with regard to certain groups of seniors that fall directly under its jurisdictional authority encompasses a range of social and health services. With respect to health services for example, the Government of Canada's direct responsibility across six federal departments makes it the fifth largest provider of health services to Canadians, a substantial number of whom are aging. Within specific federal capacity, departments ensure the availability of services for eligible First Nations and Inuit seniors, for eligible veterans of the Canadian Forces and the Royal Canadian Mounted Police and for older offenders in federal penitentiaries.

10.2 Veterans

Veterans Affairs Canada (VAC) has a mandate to deliver programs under legislation such as the *Department of Veterans Affairs* Act and the *Pension Act*. In 2006, with approximately 7 percent of all

Health Canada. *Healthy Canadians, A Federal Report on Comparable Indicators*, 2006.

seniors being veterans, Canada had close to 234,000 veterans from the First and Second World Wars and the Korean War, plus 580,000 Canadian Forces veterans (Regular Forces and primary reserves).

While services and benefits for eligible veterans can include pensions for disability, economic support in the form of allowances, home care services and health care benefits and services, only a small

The Committee notes that not all veterans are eligible for services through Veterans Affairs Canada.

portion of Canada's veterans receive benefits and services from VAC. A departmental report noted that, "as of March 2006, approximately 68 percent of war service Veteran clients (62,594) and all of Canadian Forces clients (45,589) were receiving a disability pension. In addition,

approximately 74,000 Veterans and 24,000 survivors were receiving benefits and services under the Veterans Independence Program. Finally, approximately 113,000 Veterans received treatment benefits in 2005-2006."

10.2.1 Programs and Services

The receipt of a disability pension or a War Veterans Allowance creates the opening for eligibility to other programs and services such as the Health Care Program and the Veterans Independence Program. Program eligibility is based on criteria such as assessments of finances and functionality rather than age.

However, one witness described a complicated, inconsistent and sometimes inequitable process, suggesting that the intensive screening program for eligibility discourages people from applying and keeps some people out of programs. Most witnesses wanted a program based on needs rather than on complex service-based eligibility requirements. They maintained that it is neither feasible nor necessary to relate a current health condition in the later years to a specific war service-related event, pointing out that it is virtually impossible to link a current health condition to something that happened as far back as 1944.

¹⁷⁸ Veterans Affairs Canada, *Five-Year Strategic Plan, 2001-2006, Update 2006-2007*, p. 14.

There is a poverty criterion, the means test, but the major criterion is being able to tie a current health issue to something that happened during war service. It is a complex process.

The Health Benefits Program provides coverage for medical, surgical or dental examinations; treatment by health professionals; surgical or prosthetic devices or aids; and prescribed drugs. The Committee heard that:

Currently 40 percent of war service veterans receive Veterans Affairs Canada health benefits. We take the position that all war service veterans who could benefit from VAC services should be eligible. In other words, "a vet is a vet is a vet."¹⁷⁹

Numerous witnesses told the Committee that the Veterans Independence Program (VIP) is the kind of rich and enhanced homecare program for seniors that all federal, provincial and territorial governments should look to as a model. It was seen as providing the high level of care that seniors across Canada need and deserve. It assists with the costs of certain services provided at the client's home such as grounds keeping, housekeeping, personal care, nutrition, health care and support. It can also cover some transportation costs, ambulatory health care, and home adaptations. It was recently expanded to provide housekeeping and/or grounds maintenance benefits to eligible low-income and disabled survivors of certain traditional war service veterans. Overall, it is based on a continuum of service or graduated care model, emphasizing early intervention and providing a variety of services to respond to changing needs.

Departmental data indicates that these basic home support services help keep people living in the community and prevent early uptake on more expensive facility-based care. The average VIP cost for nursing home care and adult residential care is over \$8,000 per client, for housekeeping the average cost was \$1,787 and for grounds maintenance \$675 per client in 2005-06. The evidence supports home care as a cost-effective substitute for residential long-term care. Departmentally, the average residential care facility cost for community care is approximately one quarter of the average cost for

¹⁷⁹ Victor Marshall, Professor of Sociology, Institute on Aging, University of North Carolina, *Evidence*, February 19, 2007.

priority access beds available on a contracted basis.¹⁸⁰ Using data from Veterans Affairs Canada clients, Table 10.1 demonstrates that caring for community clients costs less per year than caring for facility clients, even when the informal caregiving work of family members is allocated a financial cost.

Table 10.1 Costs to Government, Clients and/or Caregivers, and Total Societal Costs, for Community and Facility Clients¹⁸¹

	Care Levels (based on SMAF Scores)	Total Costs to Government	Total Costs to Clients and/or Caregivers	Total Societal Costs
Community	Level 1&2	4,837	14,411	19,248
	Level 3	5,905	20,194	26,099
	Level 4	12,783	31,083	43,866
	Level 5	14,875	50,297	65,172
	Level 6&Up	14,581	42,263	56,844
	Overall Average	9,104	27,904	37,008
Facility	Level 4	63,008	24,239	87,247
	Level 5	67,675	23,617	91,292
	Level 6	64,594	24,463	89,057
	Level 7	64,811	23,975	88,786
	Level 8	65,296	19,053	84,349
	Level 9	64,203	19,120	83,323
	Overall Average	65,175	22,201	87,376

In addition to these cost savings and the positive impact in supporting veterans and spouses in their homes and communities, the VIP has also translated into a dramatic reduction in the demand for long-term care. It was reported that in a Veterans Affairs Canada study in Ottawa, Halifax and Vancouver, the three communities saw

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¹⁸⁰ Veterans Affairs Canada, *Evaluation of the Veterans Independence Program* (VIP), December 2006.

Excerpt from Miller, Jo Ann, Marcus Hollander, Margaret MacAdam The Continuing Care Research Project for Canada and the Government of Ontario: Synthesis Report, April 2008.

p. 29. See Appendix IV for a more detailed breakdown of costs.

waiting lists for veterans to go into long-term care drop by 90 percent because of the VIP program. When offered an alternative, most participants chose to remain at home rather than move to a long-term care facility. However, the Committee also heard that although eligibility has gradually been extended over the years since its inception, there are still differences in the benefits that are available to the different groups of veterans.

Veterans Affairs Canada also partners with groups such as the Royal Canadian Legion to encourage supportive housing for veterans as another option to delay institutionalization. According to one witness, the Royal Canada Legion has approximately 150 facilities with over 7,500 units, making the Legion "one of the most successful providers of safe, affordable housing for veterans and seniors across Canada." Witnesses wanted more supportive housing options for senior veterans, especially those options that would be close to families and enable spouses to remain together.

10.2.2 The Way Forward

Several witnesses talked about the integrated services approach outlined in the 2006 report of the Gerontological Advisory Council to Veterans Affairs Canada. This integrated services approach would ensure that veterans do not slip through the cracks. It would place the veteran in the context of his or her family and community and try to provide care programs that are close to home. It would be based on the concept of providing needed front-line social and health services to eligible veterans, regardless of where they happen to be. It would aim at removing the separation between health and social services, facilitating any transition between provincial hospital and other health

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¹⁸² Doug Rapelje, Representative, Senior Citizens Advisory Committee to the City of Welland, *Evidence*, May 9, 2008.

See David Pedlar and John Walker, "Brief Report: The Overseas Service Veteran at Home Pilot: How Choice of Care may Affect Use of Nusring Home Beds and Waiting Lists," Canadian Journal on Aging, Vol. 23 No. 4, pp. 367-369.

Pierre Allard, Director, Service Bureau, The Royal Canadian Legion, *Evidence*, December 10, 2007.

Gerontological Advisory Council, *Keeping the Promise, The Future of Health Benefits for Canada's War Veterans*, Report of the Gerontological Advisory Council to Veterans Affairs Canada, November 2006.

services and social services such as home care services. It would deliver care to the end of the veteran's life.

However, these witnesses noted that to date the proposals of the Gerontological Advisory Council had not been acted on by the Minister of Veterans Affairs. According to them, the recommendations would save money and had already passed the three crucial tests of meeting the needs of the veterans' groups, of being realistic in terms of the clinical and health care experience of the service providers and of meeting the scientific criteria of the academic researchers on the council.

The Committee commends
Veterans Affairs Canada on its
success and its cost
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program for veterans that is
viewed as the gold standard for
all seniors across Canada.

The Committee commends Veterans Affairs Canada on its success and its cost effectiveness in creating a program for veterans that is viewed as the gold standard for all seniors across Canada. The Veterans Independence Program provides comprehensive and flexible services for eligible clients. However, in our view, the department

could go even further and provide a fully integrated care approach for all its clients. It could start by ensuring access to all necessary services for all war service veterans and could then gradually move beyond to other men and women who have served Canada in conflict zones.

The Committee recommends:

30. That the federal government adopt the integrated service approach recommended by the Gerontological Advisory Council to Veterans Affairs Canada and begin by expanding the eligibility for programs at Veterans Affairs Canada to all surviving war service veterans, not just to clients of the department.

Victor Marshall, Professor of Sociology, Institute on Aging, University of North Carolina, Evidence, February 19, 2007; François Béland, Full Professor, Faculty of Medicine, Université de Montréal, Co-director, SOLIDAGE, Evidence, April 7, 2008; and Doug Rapelje, Representative, Senior Citizens Advisory Committee to the City of Welland, Evidence, May 9, 2008.

10.3 First Nations and Inuit

Two federal departments have primary responsibility for health and social services provided specifically to First Nations and Inuit seniors. Indian and Northern Affairs Canada through the Indian Act has responsibilities for registered Indians and certain Inuit. For Health Canada, the services provided to eligible First Nations and Inuit through the First Nations and Inuit Health Branch are based primarily on the 1979 Federal Indian Health Policy advocating more direct health services control by First Nations and Inuit communities.

Although a significant percentage of First Nations and Inuit people in Canada live in urban areas, both departments focus on programs and services for those First Nations on-reserve or for Inuit in specific Arctic communities. Early interpretation of *The Constitution Act*, 1867 allowed for a division of responsibility for Aboriginal peoples, whereby some are accorded status and access to programs and services through federal recognition while others such as non-status Indians and Métis are not.

In general, the federal government argues that it transfers health and social funding to the provinces and territories on a per capita basis, maintaining that services for First Nations and Inuit are among those to be covered by other jurisdictions. Provinces and territories argue that the calculation for federal funding on a per capita basis does not take into account the cost of delivery, particularly when socio-economic status and isolation factors are considered.

Witnesses told the Committee that ongoing jurisdictional arguments have resulted in fragmentation of services, with serious gaps and overlaps in the provision of services to First Nations and Inuit seniors. They emphasized that the poor coordination and widely varying service provision must be placed against the reality that the needs in many First Nations and Inuit communities across the country are of the most basic kind. As well, the impact of residential schools continues to affect not only the seniors who attended, but also subsequent generations of their families and ultimately the level of support and care that they can provide. It was noted that almost half of First Nations seniors aged 50 and over attended residential school

Elmer Courchene, Elder, and Richard Jock, Chief Executive Officer, Assembly of First Nations, *Evidence*, May 14, 2007.

where many experienced isolation from family and community, verbal or emotional abuse and loss of cultural identity. 188

Despite historical evidence of robust health, chronic diseases are at disproportionately high levels for First Nations and Inuit peoples in comparison with other Canadians. Diabetes alone is the leading cause for disabilities for those over 65 years of age. Among First Nations people over 65 years, 30 percent of men and 32 percent of women have diabetes. For their non-Aboriginal counterparts, the rates

The Committee urges the federal government to examine the appropriate age of eligibility for access to services for aboriginal seniors.

are 14 percent of men and 11 percent of women. 190

Witnesses argued that poor health and social status in these populations makes it more appropriate to set 55 years as the age of eligibility for access

to services. Socio-economic factors, such as high rates of poverty, low levels of education, limited employment opportunities, inadequate housing, and deficiencies in sanitation and water quality, have resulted in poor health outcomes and lower life expectancy for First Nations and Inuit populations compared to the general Canadian population. Given the shorter life expectancy of aboriginal seniors, the Committee urges the federal government to examine the appropriate age of eligibility for access to services for aboriginal seniors.

10.3.1 Programs and Services

Indian and Northern Affairs Canada (INAC) and Health Canada generally provide funding to First Nations on-reserve who in turn deliver the necessary social and health programs and services relevant to seniors. Thus, INAC offers social and income assistance services to First Nations seniors on reserves similar to those delivered by provinces in an effort to meet basic needs for food, clothing and shelter. While Health Canada supports some on-reserve nursing stations and health centres, the expectation is that First Nations will

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Assembly of First Nations, <u>A Report from the Assembly of First Nations to the Special Senate Committee on Aging</u>, May 2007.

Elmer Courchene, Elder, and Richard Jock, Chief Executive Officer, Assembly of First Nations, *Evidence*, May 14, 2007.

¹⁹⁰ NAHO, Brief to Committee, November 26, 2006.

¹⁹¹ Elmer Courchene, Elder, and Richard Jock, Chief Executive Officer, Assembly of First Nations, *Evidence*, May 14, 2007.

access hospital services and primary health care services provided by provincial and territorial governments. For Inuit seniors, the relationship of INAC and Health Canada in the provision of general health and social services is less clear.

With respect to income assistance programs, the Assembly of First Nations noted that nearly 80 percent of First Nations seniors rely on income from government sources, including Employment Insurance, Old Age Security and social assistance. As well, 7 percent of First Nations seniors (aged 55 and over) received a disability allowance in 2001. Inuit representatives noted that participation rates in OAS and GIS are very low for their seniors.

Witnesses emphasized the deplorable housing situation for seniors in First Nations and Inuit communities where many live in

overcrowded, poorly ventilated, unhealthy housing. The Committee heard during its visit to Manitoba that inadequate housing can mean that as many as 12 people live in a single house requiring some occupants to take turns to sleep. Witnesses explained that 58 percent of First Nations seniors live in band-owned housing and over one-third report mould or mildew in their homes. ¹⁹³ Inuit seniors too are seriously affected by limited housing and high costs of living that threaten their already minimal income. Too

The Committee notes the needs of First Nations and Inuit seniors are of the most basic kind, including access to adequate housing.

often, they must either live in their children's multi-generational crowded homes or have other family members move into their small, subsidized residences.¹⁹⁴

One health program that is provided to both eligible First Nations and Inuit clients, regardless of residency, is Health Canada's Non-Insured Health Benefits (NIHB) program. This program offers coverage for health-related goods and services such as dental, drug, vision, crisis mental health services, medical equipment and supplies and medical transportation benefits not available through provincial or territorial systems. While the client population for this program is

¹⁹² Assembly of First Nations, A Report from the Assembly of First Nations to the Special Senate Committee on Aging, May 2007, p. 13.

Elmer Courchene, Elder, Assembly of First Nations, *Evidence*, May 14, 2007.

¹⁹⁴ National Aboriginal Health Organization (NAH0), *Evidence*, November 27, 2006.

described as relatively young, seniors (defined by Health Canada as clients 65 years of age and over) represent about 6 percent of the total population, a proportion of the total population which has increased since 2000. 195

With respect to key federal programs relevant to home care for seniors, witnesses remarked on the overlap between Health Canada's First Nations and Inuit Home and Community Care Program and Indian and Northern Affairs Canada's Assisted Living Program/Adult Care Program. Despite years of interdepartmental consultation, the lack of coordination between these two programs contributes to ongoing gaps and duplication in the provision of care. The Committee heard that almost one-half of First Nations seniors are in need of one or more home care services, but only one-third receive care. 197

In addition to in-home care that complements that provided by Health Canada, the Assisted Living/Adult Care Program includes an institutional care component in institutions which may be located on a reserve or operated by the province. However, it was noted that only 0.5 percent of First Nations communities have long-term care facilities, forcing most First Nations seniors in need of care to leave their homes and communities. This means that seniors requiring institutional care are often placed in provincial/territorial facilities located a great distance away. The detrimental effects of being removed from their communities may include: culturally inappropriate care (including the possibility of language barriers); isolation from family and friends; loss of opportunity to be a part of their community; and the loss of their social role as an Elder.¹⁹⁸

While Health Canada's First Nations and Inuit Home and Community Care Program covers the cost of equipment and medication for residents in the home, nurses often confront administrative barriers in accessing the basic equipment necessary to do their jobs and meet the needs of their clients. For instance, the Committee has heard that a request for basic medical supplies such as gauze, tape and saline requires a prescription from a physician. This affects timely access to supplies and equipment, since physicians are

¹⁹⁵ Health Canada, *Non-Insured Health Benefits: Annual Report 2006/2007*, Ottawa: 2008.

¹⁹⁶ Indian and Northern Affairs Canada, *Evidence*, December 4, 2006.

¹⁹⁷ Elmer Courchene, Elder, Assembly of First Nations, *Evidence*, May 14, 2007.

¹⁹⁸ Carole Lafontaine, NAHO, *Evidence*, November 26, 2006.

seldom readily available, particularly in remote communities. Furthermore, witnesses alerted the Committee to the importance of foot care for seniors suffering from diabetes. Witnesses noted that in Manitoba, for example, only approximately 21 of 64 communities have access to such services.

In spite of these challenges, the Committee observed the dedication of the health care staff and band council during its visit to Manitoba. While nurses deal with inadequate supplies, outdated technology and low wages, they revealed optimism and a strong commitment to providing the best possible care for their older residents. This despite the fact that workers on-reserve are paid less than their equivalents off reserve and pay scales for nurses in the home care program funded by Health Canada are different from those in the long-term care facility funded by INAC.

Given the limited health care and social program resources, First Nations communities often need to make difficult choices about what services they can provide. For example, the Committee heard that there is no allowance for hospice palliative care in the First Nation and Inuit health budget envelope. It also heard that respite services decrease as available resources allocated to other needs increase. 199 Similarly, because there is not enough staff to provide on-call palliative care services or other supportive services, some of the home, palliative and hospice care services are provided informally. however, often causes economic and other strain on the caregivers as caregiving can interfere with paid opportunities. 200 In addition, caregivers do not receive the proper training required to provide quality home care to seniors in First Nations and Inuit communities.

10.3.2 The Way Forward

Seizing the opportunity for aging First Nations and Inuit populations means ensuring that programs and services are culturally sensitive to their needs. Many witnesses emphasized that when services are not culturally sensitive, they may not be used. Okalik Eegeesiak, Director of Socio-Economic Development at the Inuit

¹⁹⁹ Visit to Sagkeen First Nation in Manitoba.

Health Canada, The Health Human Resources In Continuing Care in First Nations and Inuit Communities, Technical Report, April 2006, p. 23.

Tapiriit Kanatami, emphasized the need for policies and programs to be sensitive to Inuit realities, stating, "Many times, a square is made to fit into a circle. As Inuit communities, it is difficult to be an afterthought...." According to Debra Keays-White, Regional Director of the Atlantic Region, First Nations and Inuit Health Branch:

Services that are culturally appropriate are an important factor in program delivery. For First Nations elders, admission to a supportive housing or long term care facility requires relocation far away from their home and culture. There are no long term care residential options in First Nations communities, and our clients tell us that the off-reserve facilities are not culturally safe. Currently, the number of First Nations elders in Atlantic Canada who choose this option is negligible.

Evidence, May 13, 2008

Funding for all programs is a major concern. As it traveled across the country, the Committee was struck by glaring discrepancies in services and the facilities made available to First Nations seniors in comparison to the rest of the Canadian population. Whether these discrepancies arise out of jurisdictional wrangling, inflexible funding formulas or insufficient funding, one thing is clear – the situation must be rectified as soon as possible.

The Assembly of First Nations presented compelling evidence that the funding received by First Nations has not kept pace with the costs of providing services. This health and social fiscal imbalance has resulted in a gradual impoverishment of community budgets creating an imbalance that severely impacts the ability of First Nations governments to address the needs of their population, including First Nations seniors.

Since 1997-98, the Government of Canada has maintained an arbitrary 2 percent cap on spending increases for core services, which includes all social programming provided to First Nations communities. Similarly, in 1996-97, the Indian Health Envelope, containing all core programs of the First Nations and Inuit Health Branch of Health

²⁰¹ Okalik Eegeesiak, Director, Socio-Economic Development at the Inuit Tapiriit Kanatami, *Evidence*, May 14, 2007.

²⁰² Elmer Courchene, Elder, and Richard Jock, Chief Executive Officer, Assembly of First Nations, *Evidence*, May 14, 2007.

Canada has been generally capped at 3 percent annually. These caps ignore basic cost drivers such as population growth, aging and inflation. These caps also represent less than one-third of the average 6.6 percent increase that most Canadians enjoy through the Canada Health and Social Transfers until 2013.²⁰³

First Nations and Inuit communities vary in size and remoteness and, in turn, face varied challenges regarding the adequacy of funding for health services. Small communities face unique issues and the Committee learned that some are compensating by pooling their resources together to purchase essential services such as health care workers. Despite these innovations, there is need for more support from the federal government in the way in which funding is allocated to allow communities to meet their needs.

However, it is clear that the larger picture is one of underfunding created by caps on health and social programs that have not met the increased needs of the population where safe drinking water, appropriate housing and a range of health and social programs are essential now.

The Committee recommends:

- 31. That the federal government address the needs of First Nations and Inuit seniors and their communities, including the need for:
 - More and improved housing;
 - Increased attention to safe drinking water, diet, foot care and other diabetic needs;
 - Measures to ensure wage parity among care providers;
 - Increased home care and hospice palliative care services;
 - More support for informal caregivers;

Elmer Courchene, Elder, and Richard Jock, Chief Executive Officer, Assembly of First Nations, *Evidence*, May 14, 2007.

- The removal of the funding cap for the Non-Insured Health Benefits Program; and
- Measures to fully integrate the range of programs currently available to seniors on First Nations reserves and in Inuit communities into a seamless system comparable to that employed by Veterans Affairs Canada.

10.4 Federal Offenders

The Correctional Service of Canada (CSC) as mandated by the Corrections and Conditional Release Act is responsible for the care and custody of offenders serving a sentence of two years or more. Older offenders are defined by CSC as those 50 years old and over, with an aging process accelerated by factors which include lower socioeconomic status, limited access to medical care and difficult lifestyle. According to Ross Toller, Assistant Commissioner, Correctional Operations and Programs for the Correctional Service of Canada, federal offenders aged 50 years and over totalled 4,339 in 2007 and comprised 20 percent of the federal population. Of these, 2,068 were in the prison population and 2,271 were in the community supervision population.

Howard Sapers, Correctional Investigator, outlined the psychosocial concerns around the care of older offenders as follows:

... estrangement from, or lack of connection to, other inmates, given the relatively small percentage of older inmates; physical vulnerability to more serious consequences of assault; more difficulty adjusting to a new environment, and a greater length of time to do so; a higher rate of completed suicide, and a greater possibility of dying during incarceration; and a higher incidence of loss of external support systems — for example, spouse, family and friends.

Evidence, February 4, 2008

10.4.1 Programs and Services

At present, the Correctional Service of Canada operates 58 institutions at minimum, medium, maximum and multi-level security levels. As well, CSC currently manages 16 community correctional centres for offenders on conditional release and on long-term supervision orders. In addition, approximately 200 community residential facilities, commonly called halfway houses, are operated by community-based agencies under contract with CSC.²⁰⁴ Within these settings, CSC is responsible for a wide range of social, employment, housing and health programs and services with particular relevance to older offenders.

The Committee heard about various actions being taken to adapt to the older offender population.²⁰⁵ Witnesses pointed out that age is one consideration during the intake assessment process whereby considerations could be made within the institution for such factors as penitentiary placement, program and employment requirements, "stand to count" security requirements, and personal property retention. On the physical side, accommodations include step stools to facilitate access to and from escort vehicles, cells designed for wheelchairs, plumbing to accommodate physically disabled inmates, placement of oxygen/respirator equipment and increased ramps and lifts. On the social side, there is reintegration programming whereby aging offenders can demonstrate progress through transfers to reduced security or conditional release. For health, there is a special assessment tool for those aged 50 years and older, palliative care quidelines involving a multidisciplinary approach and training nurses in geriatrics. Older inmates can also receive training and support to work as peer assistants.

Mr. Toller, Assistant Commissioner, Correctional Operations and Programs, also stated that, with certain exceptions, parole by exception could be granted at any time to "an offender who is terminally ill, whose physical and mental health is likely to suffer serious damage if the offender continues to be held in confinement, for whom continued confinement would constitute an excessive hardship

²⁰⁴ CSC Review Panel, A Roadmap to strengthening Public Safety, 2007.

²⁰⁵ Ross Toller, Assistant Commissioner, Correctional Operations and Programs, Correctional Service of Canada, *Evidence*, February 4, 2008.

that was not reasonably foreseeable at the time the offender was sentenced..." 206

Howard Saper, Correctional Investigator, acknowledged some of the positive initiatives implemented for aging offenders. For example, he mentioned the palliative care program at the Pacific Institution/Regional Treatment Centre and the "peer care assistant" program that develops expertise in caring for elderly offenders, and initial efforts to accommodate physical needs.

However, he expressed concerns about the lack of comprehensive plan focused on the needs of older offenders. questioned why older offenders with serious mobility impairments or illnesses that negate public safety concerns continue to be housed in medium and maximum security institutions. He indicated that the older offenders with mental health issues and cognitive deficits are vulnerable to victimization by other offenders, resulting in segregation for their own protection. He pointed out that the long wait lists for regular programs delay participation and delay conditional release. As well, the absence of specific programs for older offenders results in their withdrawal from health activities, through fear of interacting with other inmates or through physical and mental inability. He pointed to the limited access to patient-centred chronic, long-term and palliative care, the inadequate provision of special diets and the significant delays in obtaining items such as hearing aids, dentures and adult incontinence products critical to well-being and dignity. He called for improved staff training to address the needs of older offenders and for increased financial and human resources to meet their legally required and clearly identified needs.

Kim Pate, Executive Director, Canadian Association of Elizabeth Fry Societies, spoke about aging female prisoners. She emphasized that the chronic and aging diseases such as menopause, osteoporosis and diabetes affect women more profoundly and for, female offenders, non-pharmaceutical interventions such as exercise, diet and other alternatives are not generally available in the federal institutions. She noted the perception that women with aging problems such as osteoporosis or a breast lump may not receive medical assessments as quickly as men. As well, some women do not have access to incontinence products and must use menstrual pads instead. She also

Ross Toller, Assistant Commissioner, Correctional Operations and Programs, Correctional Service of Canada, February 4, 2008.

noted that individuals may be expected to care for other ailing inmates without any training or compensation.

On the question of financial and other work benefits, Kim Pate pointed out that:

Aging prisoners do not have access to pension benefits. They are expected to work or receive minimal resources while in the institution.... When they are in the institution, they want the same opportunities that exist in the community. For example, as they are aging and getting older, to have either shorter work weeks or work days and, what I have termed, pension opportunities, so they would not end up with virtually no pay.

Evidence, February 4, 2008

10.4.2 The Way Forward

The Committee recognizes that CSC faces many challenges with respect to the safety, health and accessibility for its older offenders. At present, many of the penitentiaries and the community facilities

cannot accommodate the physical, social and safety needs of these older men and women. However, the task is not impossible and logic suggests that the Government of Canada can move forward in a compassionate way.

The Committee notes that palliative care guidelines for application within Correctional Service institutions had been developed within the last few years. In January 2008, the Commissioners' health services directive

The Committee urges the federal government to develop a comprehensive plan of integrated care for older offenders both inside penitentiaries and in the community facilities, including provisions for early release provided public safety can be guaranteed and available treatment options are realistic.

was changed and the requirement that CSC's Palliative Care Guidelines be initiated upon diagnosis of a terminal illness was added.²⁰⁷

For the older inmates, access to community resources at an earlier stage could be appropriate. Thus, individuals who are not a risk

²⁰⁷ Correctional Services of Canada, *Policy Bulletin*, No. 243, January 2008.

to the community or who could be eligible for release might start work releases. For women in particular, work releases might involve care for grandchildren or other types of home support. Also conditional release arrangements for appropriate age and disability related placements in private senior homes or palliative care facilities could be an option instead of developing such services in prisons.

The Committee urges the federal government to develop a comprehensive plan of integrated care for older offenders both inside penitentiaries and in the community facilities, including provisions for early release provided public safety can be guaranteed and available treatment options are realistic.

10.5 National Leadership and Indirect Responsibility

The Government of Canada's national leadership role involves the less tangible role of catalyst and motivator combined with its concrete and constitutional spending power capacity. Thus, while the individual provincial and territorial governments have primary responsibility for the delivery of health and social care services to their respective senior citizens, the Government of Canada supports the publicly funded system through transfer payments and through various pieces of legislation such as the Canada Health Act, Canada Pension Plan, Old Age Security Act, etc. In addition, its investments in the development of services for official language minority seniors under the Official Languages Act and for Aboriginal peoples defined under The Constitution Act, 1982 as the "Indian, Inuit and Métis peoples of Canada" have already resulted in community-led initiatives endorsed by provincial and territorial governments. The Committee heard enough testimony about these two groups and about the need for leadership by the Government of Canada to present their cases.

10.6 Official Language Minority Seniors

Witnesses argued that the federal government has an obligation under the *Official Languages Act* to ensure that policies and programs relating to aging reflect the realities within official language minority

communities across Canada.²⁰⁸ They pointed to section 41 of the *Official Languages Act*, which states that the federal government is "committed to enhancing the vitality of the English and French linguistic minority communities in Canada and supporting and assisting their development; and fostering the full recognition and use of both English and French in Canadian society."²⁰⁹

The proportion of the population aged 65 years and over which belongs to an official language minority group varies across the country; for example, from less than 1 percent in Newfoundland and Labrador to over 76 percent in northern New Brunswick. Also, the francophone population is aging much faster than its anglophone counterpart, particularly in rural regions as young families leave for education and employment opportunities. ²¹⁰

Health Canada's move in 2001 to establish separate consultative committees for the French and the English-speaking minority communities and their subsequent strategic plans with recommendations represented a significant step in the federal commitment to enhance the vitality of these communities.²¹¹ Cognizant of jurisdictional divisions, both groups acknowledged that the federal government's role would be limited to establishing or administering national standards or principles, providing funding, and promoting cooperation between provinces and territories and the official language minority communities. The advice found its way into the 2003 federal Action Plan for Official Languages issued by the Privy Council Office and resulted in federal financial investments until 2008.

10.6.1 Current Challenges

Despite these federal commitments, witnesses appearing before the Committee identified ongoing barriers to improving access to health and social services for seniors living in official language minority

Annie Bédard, Director General, Conseil communauté en Santé du Manitoba, *Evidence*, June 1, 2008.

²⁰⁹ Ibid.

²¹⁰ Statistics Canada, Minorities Speak Up: Results of the 2006 Survey of the Vitality of Official-Language Minorities, Ottawa: 2007.

Health Canada, Report to the Federal Minister of Health: Consultative Committee for French-Speaking Minority Communities, September 2001, p. 7 and Health Canada, Report to the Federal Minister of Health: Consultative Committee for English-Speaking Minority Communities, July 2002, p. 21.

communities. First, training and retention of Francophone health care workers continues to pose a problem despite innovative programs being developed at universities and colleges across the country. Witnesses testified that students often ended up choosing to work in the location of the host universities, rather than returning to their communities. The Committee also learned that official language minority communities lacked resources at the local level to recruit Francophone immigrants into health care professions by providing the necessary intercultural training. 214

In addition to human resources issues, the Committee also heard that budgetary constraints limited these communities' abilities to provide health services in the language of choice to official language minority seniors. Health administrators testifying before the Committee reported that they could not set aside specific funds for the provision of bilingual services while maintaining the quality and quantity of existing health care services.²¹⁵

Witnesses testified that the absence of culturally appropriate health and social services in official language minority communities was having a negative impact on seniors' health outcomes. In particular, the absence of medical treatment in the appropriate language has often led to misdiagnosis by doctors. In his appearance before the Committee, Louis Bernardin, of Villa Youville, a Francophone seniors' residence located in St-Anne, Manitoba, told the story of how one of the residents of his facility was misdiagnosed with dementia due to language barriers:

... there was a woman, Ms. Mettai, who lived her whole life in Winnipeg. She was a francophone who had married an anglophone, and had lived her entire life in English. But when the time came to put her in a home, they looked for a francophone one, and we were the only one, which meant that they had to move her to Ste. Anne. The lady was very forgetful; you know, she had all the symptoms of dementia. She eventually came into some money, and so under the Public Cost Fee program, she saw a doctor

²¹² Jean-Luc Bélanger, President, l'Association acadienne et francophone des aînées et aînés du Nouveau-Brunswick, *Evidence*, May 13, 2008.

²¹³ Aurèle Boisvert, President, South Eastman Health, *Evidence*, June 2, 2008.

²¹⁴ Charles Gagné, Director General, Centre Taché and Foyer Valada, June 2, 2008.

²¹⁵ Aurèle Boisvert, President South Eastman Health, *Evidence*, June 2, 2008.

who assessed her. This doctor declared that she was insane and unable to manage her own affairs. When I heard about this, my first reaction was that I was furious because they came in through the back door, assessed one of my residents without even informing me of the fact. But they had conveniently forgotten that I was running a private facility and that they had no right to do what they did. So I brought in a psychiatrist from St. Boniface, a francophone, who reversed the first doctor's diagnosis. This shows that language is extremely important.

Evidence, June 2, 2008

The Committee also heard that language barriers result in seniors not understanding instructions regarding their treatment.²¹⁶ Finally, the lack of health care services in the appropriate language reduced the overall quality of care by undermining doctor-patient relationships due to miscommunication and increased anxiety levels among patients.²¹⁷

The Committee heard that in addition to negatively effecting health outcomes, the lack of social and health services provided in the language of choice also meant that seniors in official minority situations face greater risks of social isolation. For most seniors, moving to an assisted living or long term care facility is a time of sadness and anxiety. For official language minority seniors, these feelings are compounded by the fact that often these living environments only provide services in the dominant language and culture of the region. As a result, official language minority seniors experience a greater degree of social isolation, detached not only from their homes and communities, but their language and culture as well.²¹⁸

Assisted living facilities that cater to seniors living in linguistic and cultural minority situations were seen by witnesses as a means of ensuring that these seniors do not live their final years isolated from their communities. Jean Balcaen, President of Villa Youville, articulated

²¹⁶ Aurèle Boisvert, President of South Eastman Health Inc., *Evidence*, June 2, 2008.

Annie Bédard, Director General, Conseil communité en santé du Manitoba, *Evidence*, June 2, 2008.

²¹⁸ Jean Balcaen, President of Villa Youville, *Evidence*, June 2, 2008.

that his clients were able to adapt more easily to life in the facility, because he provided Francophone seniors with the opportunity to live in a familiar Catholic Francophone environment. For these seniors, the transition to assisted living therefore represented a return and reintegration to their cultural communities of origin, rather than a time of isolation and sadness. Thus, for official language minority seniors, "aging in place" means not only being able to grow older in their place of choice, but also being able to live in the language and culture of their choice.

10.6.2 The Way Forward

The Committee heard from witnesses that the existing networking models carried out by the Société Santé en français and the Consortium national de formation en santé have been effective in promoting cross-jurisdictional cooperation and innovative human resource initiatives, as well as mobilizing political will in support of increased access to health care services for seniors in official language minority communities. The Committee is pleased to learn that the Government of Canada plans to continue funding these Health Canada initiatives, as articulated in the recently released *Roadmap for Canada's Linguistic Duality 2008-2013: Acting for the Future.* The Committee also applauds the fact that seniors, as well as other vulnerable populations, will remain the focus of these programs.

The Committee recommends:

32. That, pursuant to its role under the Official Languages Act, the federal government establish effective interdepartmental collaboration on official language minority seniors that includes participation by seniors in advisory groups and continue to earmark federal funds for the development of new models of service delivery for these official language minority seniors.

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²¹⁹ Jean Balcaen, President of Villa Youville, *Evidence*, June 2, 2008.

²²⁰ Charles Gagné, Director General, Centre Taché and Foyer Valada & Annie Bédard, Director General, Conseil communauté en santé du Manitoba, *Evidence*, June 2, 2008.

Government of Canada, Roadmap for Canada's Linguistic Duality 2008-2013: Acting for the Future, 2008, p. 11.

10.7 Aboriginal Seniors

The Committee acknowledges that the debate about and by Aboriginal peoples is of longstanding duration and more complex than can be addressed in this report. However, it believes that the decision in 1982 to recognize this population in Canada's Constitution was an appropriate signal of direction with respect to the unique place of Aboriginal peoples in the Canadian federation. Like seniors in official language minorities communities, Aboriginal seniors are deserving of specific recognition beyond the limited number of First Nations and Inuit acknowledged in the earlier part of this chapter.

Witnesses indicated that by 2026 the percentage of Aboriginal seniors will triple. Currently, more than half of Aboriginal people live in urban or semi-urban areas where they face particular problems. Non-status Indians, non-eligible Inuit and Métis are caught in the jurisdictional wrangling among federal, provincial and territorial governments where none want to accept full responsibility. Some become caught in wrangling among governments and band or community council when trying to access programs and services.

Witnesses emphasized that while we must strive for optimal conditions for the general senior population in Canada, the vulnerable health of Aboriginal seniors requires specific attention, with interventions that are culturally appropriate.²²²

10.7.1 Current Challenges

For all Canadians, the process of Aboriginal policy negotiation carried out in 2004 and 2005 further highlighted the gap between Aboriginal and non-Aboriginal Canadians. Discussions focused on health, lifelong learning, housing, economic opportunities, negotiations and accountability.

The Committee members are aware that these discussions have not moved forward and that constitutionally recognized groups of Aboriginal peoples – Indian, Inuit and Métis – are not recognized in the same way across Canada. Governmental responsibility for Aboriginal

²²² Carole Lafontaine, Acting Chief Executive Officer, National Aboriginal Health Organization (NAHO), November 27, 2007.

peoples has been divided into First Nations on reserve and First Nations off-reserve, Inuit in recognized communities and Inuit not in communities, Indians with status and Indians without status, and Métis.

In particular, the Métis as a group have not received concerted attention from any government. One witness pointed out that the number of seniors within this population aged 55 and over is expected to rise to about 8.1 percent of our population in 2017. Across Canada, only Alberta has established specific Métis settlements and only Ontario has long-term care services available to some Métis seniors. While between 10 to 40 percent of Métis seniors continue to participate in the labour force, they are also heavily reliant upon government assistance. Housing is a major concern and as the proportion of seniors grows the need for safe, structurally sound and appropriate housing will increase. Culturally specific services to deal with the increase in chronic diseases are generally unavailable.²²³

Off-reserve Aboriginal seniors with social support report better health. One witness pointed out that many Aboriginal seniors living in Regina are isolated and are not getting out into the community to access available programs and services for seniors as they do not feel comfortable going to white-dominated agencies.

Native Friendship Centres are community service agencies that can facilitate programming for seniors in urban areas. This can include support to Aboriginal seniors seeking social or medical attention by providing a familiar face, transportation or other volunteer efforts. The challenges for these organizations is that in addition to generating their own revenue and to obtaining private sector partnerships, the centres must work continually to elicit funding from multiple diverse sources within three levels of government.²²⁴

10.7.2 The Way Forward

The need for collaboration between jurisdictions to meet the overall health care needs of First Nations and Inuit communities has

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Don Fiddler, Senior Policy Advisor, Métis National Council, Evidence, May 14, 2007.

²²⁴ Peter Dinsdale, Executive Director, National Association of Native Friendship Centres, *Evidence*, May 14, 2007.

resulted in examples like the Tripartite First Nations Health Plan between British Columbia, the Government of Canada and First Nations. In this plan, the government of British Columbia took the important step of openly recognizing and acknowledging that services provided by the province are for British Columbians, regardless of address. 226

Also, Health Canada's Aboriginal Health Transition Fund offers 5 years of one time funding to support First Nations and Inuit communities integrate federal programs with provincial and territorial health systems, and to support provinces and territories adapt their health services to meeting the needs of all Aboriginal people.²²⁷ A pilot project aimed at providing evidence on home care models and information on approaches to integration and coordination of services between jurisdictions in Manitoba has shown promising results. The Committee heard that the coordination of discharge planning between provincial hospitals and community care nurses on reserve allows a smooth transition – especially after surgery.²²⁸

As well, through Budget 2006, the federal government provided \$1.4 billion to provinces and territories for affordable housing, northern housing and housing for Aboriginal people living off-reserve. ²²⁹

The Committee applauds such actions but finds it hard to accept that the Government of Canada has left such a significant number of Aboriginal peoples in a jurisdictional quagmire. In particular, given that this population holds the record for being the most disadvantaged in terms of health, social and economic status, it calls on the federal government to step up to the plate and take concerted action to provide integrated care for Aboriginal seniors among all groups.

This Committee heard repeatedly that discussions about Aboriginal seniors need to recognize the distinct and unique needs and

²²⁶ Kwunahmen, Senior Director, First Nations Health Council, *Evidence*, June 4, 2008.

²²⁵ Health Canada, Tripartite First Nations Health Plan.

Health Canada, *Commitments to Aboriginal Health*, http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2004-fmm-rpm/fs-if-abor-auto-eng.php.

²²⁸ Jim Wolfe, Regional Director Manitoba, Health Canada, *Evidence*, June 2, 2008.

Douglas Stewart, Vice President, Policy Planning, Canada Mortgage and Housing Corporation, *Evidence*, December 4, 2006.

perspectives of diverse populations, regions and communities. Witnesses emphasized that a pan-Aboriginal approach is not effective

The Committee urges the federal government to make it a priority to work with all levels of governments to ensure that services respond to the social, physical and cultural needs of Aboriginal seniors, and that the federal government consult with Aboriginal groups about effective messaging on educational and public information relating to seniors.

and that policy construction and program delivery must be informed by specific data that captures the need according to First Nations, Inuit and Métis realities. These realities are influenced by jurisdictional status as well as language, geography and culture.

The Committee urges the federal government to make it a priority to work with all levels of governments to ensure that services respond to the social, physical and cultural needs of Aboriginal seniors, and that the federal government

consult with Aboriginal groups about effective messaging on educational and public information relating to seniors.

10.8 The Government of Canada Moves Forward As Leader

The Government of Canada has already established several structures in recognition of its national and federal role with regard to seniors. In 2007 in addition to the creation of a Secretary of State for Seniors, it established a National Seniors Council comprised of 12 members to advise the minister of human resources and social development and the minister of health. The Committee feels that it is essential for such a council to establish avenues for federal cross-departmental input from or about specific federal client groups. In this regard, the Committee emphasizes the need for the National Seniors Council to include federal clients in its membership and to make them a specific priority.

National Seniors Council, http://www.seniorscouncil.gc.ca/en/about_us/index.shtml.

The Government of Canada also coordinates an Interdepartmental Committee on Seniors that includes the large number of federal departments that have responsibilities that either directly or indirectly include seniors' issues.²³¹ It participates in the

Federal/Provincial/Territorial Ministers Responsible for Seniors Forum that meets regularly to examine seniors' issues and could be an avenue for crossjurisdictional issues. As well, since 1994 it has had a Federal Healthcare Partnership including the six key

The Committee emphasizes the need for the National Seniors Council to include federal clients in its membership and to make them a specific priority.

departments that recently set up a Working Group on Home and Continuing Care to develop federal policy for those Canadians who are the direct responsibility of the federal government. ²³²

Individual federal departments with federal clients have also set up structures but have approached their aging client groups in different ways. Veterans Affairs Canada established the Gerontological Advisory Council in 1997 to advise on policies, programs, services and trends affecting aging veteran population.²³³ Correctional Services Canada conducted a major study in 1998 and established a new division – the Older Offender Division – with the mandate "to elaborate a sound correctional strategy adapted to the needs of older offenders."234 Health Canada with Indian and Northern Affairs established a Joint Working Group on Continuing Care in 1987 that representatives from First Nations includes and Inuit communities, the Assembly of First Nations, and Inuit Tapiriit Kanatami.²³⁵ Many departments, however, have not moved to implement the recommendations received from their various advisory groups, in some instances because of a shift of priorities and in others a lack of resources.

Federal Healthcare Partnership, http://www.fhp-pfss.gc.ca/fhp-pfss/fhp-pfss.asp?lanq=enq&cont=009.

²³⁴ CSC, Older Offender Population, Where do we Stand?, http://www.csc-scc.qc.ca/text/rsrch/reports/r70/r70e-eng.shtml.

²³⁵ Indian and Northern Affairs Canada. Evaluation of Adult Care Services, 2003.

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²³¹ Canada. Addressing the challenges and opportunities of ageing in Canada: Prepared for the United Nations Commission for Social Development for the 5th Anniversary of the 2002 United Nations Second World Assembly on Ageing.

²³³ Gerontological Advisory Council, http://www.vac-acc.gc.ca/providers/sub.cfm?source=councils/qac.

This absence of forward movement speaks to the need for the Secretary of State for Seniors to cut through some of the existing disparities among different client groups as well as the duplication of services across different agencies. The programs and services for

The Committee urges the federal government to use the lessons learned from the programs for veterans and extend them with the appropriate level of resources to older First Nations and Inuit and to older federal offenders. ensure that such programs and services are integrated into a single point of entry and comprehensive needs-based assessments for all federal clients, engage interdepartmentally across the federal government and include the Treasury Board Secretariat, the Privy Council and the Department of Finance in discussions.

veterans are viewed as the standard that could be rolled out to all seniors in Canada. However, the Government of Canada can take the lead and extend it to all older veterans, First Nations and Inuit, and federal inmates. All these groups should benefit from best practices and receive the same standard of care from the federal government. In particular, they need services that are comprehensive and flexible and provided equitably to all seniors.

The Committee urges the federal government to use the lessons learned from the programs for veterans and extend them with the appropriate level of resources to older First Nations and Inuit and to older federal offenders, ensure that such programs and services are integrated into a single point of entry and comprehensive needs-based

assessments for all federal clients, engage interdepartmentally across the federal government and include the Treasury Board Secretariat, the Privy Council and the Department of Finance in discussions.

Appendix I: List of Recommendations by Framework

Framework Recommendation I: Move immediately to take steps to promote active aging and healthy aging and to combat ageism

Chapter 1, Recommendation 1 That the federal government lead an aggressive public relations campaign to portray healthy aging and to present the benefits of staying active at all ages – in volunteer work, continuous learning and physical activity.

Chapter 1, Recommendation 2 That the Canadian Institutes of Health Research fund research on mental competency, mental capability and mental capacity. The research should be driven by the information needs of policy-makers and licensing bodies to lead to the development of guidelines based on research evidence.

Chapter 1, Recommendation 3 That the federal government take a leadership role in federal-provincial-territorial initiatives to address public safety and retirement from driving in a way that is dignified, and that provinces and territories take a leadership role in education and enforcement around the medically-at-risk driver in partnership with other agencies.

Chapter 1, Recommendation 4 That the provisions of the Canadian Human Rights Act concerning mandatory retirement be amended to bring federal legislation in line with other human rights legislation in Canada.

Chapter 1, Recommendation 5

 That the federal government increase support for research into abuse and neglect issues; work closely with community organizations to avoid the duplication of efforts and to meet identified needs; and make information about abuse and neglect available in federal government staff training.

Chapter 1, Recommendation 6

 That the government reduce the immigration sponsorship period from ten years to three years similar to the regulations pertaining to conjugal sponsorship, and make a commensurate reduction in the residency requirement for entitlement to a monthly pension under the Old Age Security Act.

Chapter 4, Recommendation 16

 That the federal government adequately support research on the social network needs of seniors, and that it support organizations which provide social activities for seniors, especially those which provide culturally relevant events and activities for seniors born outside of Canada.

Chapter 4, Recommendation 17

 That the issue of lifelong learning for seniors be put on the agenda of the next meeting of the Council of Ministers of Education and the Federal, Provincial, Territorial Ministers Responsible for Seniors.

Chapter 7, Recommendation 25

 That the federal government work with the voluntary sector to identify mechanisms to recognize and reimburse the out-of-pocket expenses incurred by volunteers, particularly in activities funded through federal grants and contributions.

Chapter 7, Recommendation 26

 That the needs of the voluntary sector be the subject of further study, either by a Senate Committee or by an Expert Panel, in order to examine:

- The emerging challenges of recruiting and retaining volunteers;
- o Options to promote volunteerism; and
- The role of the federal government in supporting the capacity of the voluntary sector throughout the country, including the use of multi—year funding arrangements and the implications of introducing a tax credit for volunteering.

Framework Recommendation II: Provide leadership and coordination through initiatives such as a National Integrated Care Initiative, a National Caregiver Strategy, a National Pharmacare Program, and a federal transfer to address the needs of provinces with the highest proportion of the aging population

Chapter 2, Recommendation 7 That the federal government develop a federal initiative which would provide financial support to the provinces to facilitate the move toward integrated models of care for the elderly as a model for quality care for all ages.

The objectives of the program should be designed to ensure:

- Integration of a broad domain of services, including, but not limited to, health care, case management, home and community services, and residential care services;
- o Improved access to comprehensive care;
- Increased emphasis on health promotion, disease prevention and chronic disease management;
- Expanded multi-disciplinary teams so the most appropriate care is provided by the most appropriate provider;

- Increased emphasis on one-stop-shopping for seniors and their families; and
- Improved portability of services between provinces, including reciprocal agreements to eliminate waiting periods for services.

Chapter 3, Recommendation 14

 That the federal government create a supplementary transfer program to assist provinces and territories which have an older population in meeting the increased health care needs of their seniors.

Chapter 3, Recommendation 15

• That the federal government establish a specific time-limited fund to enable provincial, territorial and federal governmental drug benefit plans to develop a common list of drugs used by seniors; That this list form the basis of a common national formulary to be implemented by all jurisdictions as a benefit list for all Canadian seniors; and That this initial focus on seniors form the basis for a national pharmacare program.

Chapter 6, Recommendation 24

 That the federal government work collaboratively with the provinces and territories, policy-makers, stakeholders and family caregivers to establish a National Caregiving Strategy. The Strategy should form a part of a larger federal integrated care initiative.

Chapter 8, Recommendation 27

 That the federal government support education and outreach campaigns promoting geriatric and gerontological health care professions as career choices, including the funding of residency positions in geriatrics. Chapter 8, Recommendation 28 That the federal government work with the provinces and territories to address the training, recruitment and retention of home care and home support workers as part of the FPT Health Human Resource Strategy.

Chapter 9, Recommendation 29 That the federal government support and invest in the expanded use of telemedicine and telehomecare through a transition fund for provinces, a home technology fund for home and community care organizations, and by improving technology use in the provision of services to its client groups, including ensuring internet connectivity in northern and remote communities, and that Canada's official-language communities be consulted in the development of such an initiative.

Framework Recommendation III: Ensure the financial security of Canadians by addressing the needs of older workers, pension reform and income security reform

Chapter 5, Recommendation 19

- That in their next triennial review of the CPP, the Ministers of Finance consider:
 - Increasing the income replacement rate for the CPP (currently 25 percent of allowable income);
 - Increasing the maximum pensionable earnings above the average wage
 - Investigating actuarial adjustments to the Canada Pension Plan to increase the incentive to delay uptake;
 - Examining mechanisms to allow older workers who begin to collect CPP before age 65, but who are not receiving the maximum benefit, to continue to

contribute to the CPP;

- Eliminating the requirement in the CPP that individuals between the ages of 60 and 65 who apply for CPP must quit work or earn up to the maximum of CPP in the months prior to the application; and
- Introducing a drop-out provision for caregivers.

Chapter 5, Recommendation 20

 That the Government of Canada increase the Guaranteed Income Supplement to ensure that economic households are not below the poverty line as defined by the low income cut-off levels. Increases to the GIS should not result in the loss of eligibility for provincial/territorial subsidies or services for seniors.

Chapter 5, Recommendation 21

- That the federal government undertake aggressive campaigns to ensure that all eligible Canadians are receiving all retirement and agerelated benefits. This means the government should:
 - o Inform seniors of all possible federal sources of income supports when they apply for any one of them;
 - Make available to seniors application forms in aboriginal languages and the languages of larger immigrant populations; and
 - Make fully retroactive repayments with interest to eligible recipients who did not apply for OAS/GIS at 65 or CPP at 70, or who were denied benefits due to administrative errors.

Chapter 5, Recommendation 22

 That the federal government look more closely at the question of a Guaranteed Annual Income for all Canadians. Framework Recommendation IV: Facilitate the desire of Canadians to age in their place of choice with adequate housing, transportation, and integrated health and social care services

Chapter 2, Recommendation 8

 That the federal government, in consultation with the provincial and territorial ministers responsible for housing, increase the stock of affordable housing for seniors across the country, including supportive housing, by developing a long-term national affordable housing action plan.

Chapter 2, Recommendation 9

 That the federal, provincial and territorial ministers responsible for housing work to ensure that the standards for barrier-free design are consistently met by builders and enforced by inspectors.

Chapter 2, Recommendation 10

 That, as a home care is a key component of a national integrated care initiative, a Seniors Independence Program, modelled on the Veterans Independence Program administered by Veterans Affairs Canada, form part of the home care/home support component.

Chapter 2, Recommendation 11

That the federal government fund a national partnership with provinces, territories and organizations community to provide the leadership vision, standards, and best practices, awareness, and support for capacity building necessary to ensure the provision of integrated quality end-of-life care for all Canadians.

Chapter 2, Recommendation 12

 That the federal government apply the gold standard in palliative home care developed by the Canadian Hospice Palliative Care Association and the Canadian Home Care Association to veterans, First Nations and Inuit, and federal inmates.

Chapter 2, Recommendation 13

 That Canadian Institutes of Health Research funding for palliative care be renewed beyond 2009.

Chapter 4, Recommendation 18

 That the federal government actively promote both the Age-Friendly Cities Guide and the Age-Friendly Rural and Remote Communities Guide to seniors' organizations, provincial governments, and municipal governments; and That it provide financial assistance to support the implementation of the Age-Friendly Cities and the Age-Friendly Rural and Remote Communities guidelines.

Chapter 6, Recommendation 23

- That the Employment Insurance Act be amended to:
 - Eliminate the two-week waiting period before receipt of the compassionate care benefit;
 - Increase the compassionate care benefit to 75 (seventy-five) percent of the earnings of workers;
 - Increase the length of the benefit from 6 to 13 weeks; and
 - Provide access to the benefit during times of medical crisis, and not only during the palliative stages of illness.

Furthermore, the federal government must promote awareness of the compassionate care benefit among all Canadians. Framework Recommendation V: Act immediately to implement changes for those populations groups for which it has a specific direct service responsibility, and in relation to Canada's official language commitments

Chapter 10, Recommendation 30 That the federal government adopt the integrated service approach recommended by the Gerontological Advisory Council to Veterans Affairs Canada and begin by expanding the eligibility for programs at Veterans Affairs Canada to all surviving war service veterans, not just to clients of the department.

Chapter 10, Recommendation 31

- That the federal government address the needs of First Nations and Inuit seniors and their communities, including the need for:
 - More and improved housing;
 - Increased attention to safe drinking water, diet, foot care and other diabetic needs;
 - Measures to ensure wage parity among providers;
 - Increased home care and hospice palliative care services;
 - More support for informal caregivers;
 - The removal of the funding cap for the Non-Insured Health Benefits Program; and
 - Measures to fully integrate the range of programs currently available to seniors on First Nations reserves and in Inuit communities into a seamless system comparable to that employed by Veterans Affairs Canada.

Chapter 10, Recommendation 32 That, pursuant to its role under the Official Languages Act, the federal government establish effective interdepartmental collaboration on official language minority seniors that includes participation by seniors in advisory groups and continue to earmark federal funds for the development of new models of service delivery for these official language minority seniors.

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Appendix II: Complete List of Recommendations

- 1. That the federal government lead an aggressive public relations campaign to portray healthy aging and to present the benefits of staying active at all ages in volunteer work, continuous learning and physical activity.
- 2. That the Canadian Institutes of Health Research fund research on mental competency, mental capability and mental capacity. The research should be driven by the information needs of policy-makers and licensing bodies to lead to the development of quidelines based on research evidence.
- 3. That the federal government take a leadership role in federal-provincial-territorial initiatives to address public safety and retirement from driving in a way that is dignified, and that provinces and territories take a leadership role in education and enforcement around the medically-at-risk driver in partnership with other agencies.
- 4. That the provisions of the Canadian Human Rights Act concerning mandatory retirement be amended to bring federal legislation in line with other human rights legislation in Canada.
- 5. That the federal government increase support for research into abuse and neglect issues; work closely with community organizations to avoid the duplication of efforts and to meet identified needs; and make information about abuse and neglect available in federal government staff training.
- 6. That the government reduce the immigration sponsorship period from ten years to three years similar to the regulations pertaining to conjugal sponsorship, and make a commensurate reduction in the residency requirement for entitlement to a monthly pension under the Old Age Security Act.

7. That the federal government develop a federal initiative which would provide financial support to the provinces to facilitate the move toward integrated models of care for the elderly as a model for quality care for all ages.

The objectives of the program should be designed to ensure:

- Integration of a broad domain of services, including, but not limited to, health care, case management, home and community services, and residential care services;
- o Improved access to comprehensive care;
- Increased emphasis on health promotion, disease prevention and chronic disease management;
- Expanded multi-disciplinary teams so the most appropriate care is provided by the most appropriate provider;
- Increased emphasis on one-stop-shopping for seniors and their families; and
- o Improved portability of services between provinces, including reciprocal agreements to eliminate waiting periods for services.
- 8. That the federal government, in consultation with the provincial and territorial ministers responsible for housing, increase the stock of affordable housing for seniors across the country, including supportive housing, by developing a long-term national affordable housing action plan.
- 9. That the federal, provincial and territorial ministers responsible for housing work to ensure that the standards for barrier-free design are consistently met by builders and enforced by inspectors.
- 10. That, as a home care is a key component of a national integrated care initiative, a Seniors Independence Program, modelled on the Veterans Independence Program administered by Veterans Affairs Canada, form part of the home care/home support component.
- 11. That the federal government fund a national partnership with provinces, territories and community organizations to provide the leadership and vision, standards, best practices, awareness, and support for capacity building necessary to ensure the provision of integrated quality end-of-life care for all Canadians.

- 12. That the federal government apply the gold standard in palliative home care developed by the Canadian Hospice Palliative Care Association and the Canadian Home Care Association to veterans, First Nations and Inuit, and federal inmates.
- 13. That Canadian Institutes of Health Research funding for palliative care be renewed beyond 2009.
- 14. That the federal government create a supplementary transfer program to assist provinces and territories which have an older population in meeting the increased health care needs of their seniors.
- 15. That the federal government establish a specific time-limited fund to enable provincial, territorial and federal governmental drug benefit plans to develop a common list of drugs used by seniors; That this list form the basis of a common national formulary to be implemented by all jurisdictions as a benefit list for all Canadian seniors; and That this initial focus on seniors form the basis for a national pharmacare program.
- 16. That the federal government adequately support research on the social network needs of seniors, and that it support organizations which provide social activities for seniors, especially those which provide culturally relevant events and activities for seniors born outside of Canada.
- 17. That the issue of lifelong learning for seniors be put on the agenda of the next meeting of the Council of Ministers of Education and the Federal, Provincial, Territorial Ministers Responsible for Seniors.
- 18. That the federal government actively promote both the Age-Friendly Cities Guide and the Age-Friendly Rural and Remote Communities Guide to seniors' organizations, provincial governments, and municipal governments; and That it provide financial assistance to support the implementation of the Age-Friendly Cities and the Age-Friendly Rural and Remote Communities guidelines.

- 19. That in their next triennial review of the CPP, the Ministers of Finance consider:
- Increasing the income replacement rate for the CPP (currently 25 percent of allowable income);
- Increasing the maximum pensionable earnings above the average wage
- Investigating actuarial adjustments to the Canada Pension Plan to increase the incentive to delay uptake;
- Examining mechanisms to allow older workers who begin to collect CPP before age 65, but who are not receiving the maximum benefit, to continue to contribute to the CPP;
- Eliminating the requirement in the CPP that individuals between the ages of 60 and 65 who apply for CPP must quit work or earn up to the maximum of CPP in the months prior to the application; and
- o Introducing a drop-out provision for caregivers.
- 20. That the Government of Canada increase the Guaranteed Income Supplement to ensure that economic households are not below the poverty line as defined by the low income cut-off levels. Increases to the GIS should not result in the loss of eligibility for provincial/territorial subsidies or services for seniors.
- 21. That the federal government undertake aggressive campaigns to ensure that all eligible Canadians are receiving all retirement and age-related benefits. This means the government should:
- Inform seniors of all possible federal sources of income supports when they apply for any one of them;
- Make available to seniors application forms in aboriginal languages and the languages of larger immigrant populations; and
- Make fully retroactive repayments with interest to eligible recipients who did not apply for OAS/GIS at 65 or CPP at 70, or who were denied benefits due to administrative errors.
- 22. That the federal government look more closely at the question of a Guaranteed Annual Income for all Canadians.

- 23. That the Employment Insurance Act be amended to:
- Eliminate the two-week waiting period before receipt of the compassionate care benefit;
- Increase the compassionate care benefit to 75 (seventy-five) percent of the earnings of workers;
- o Increase the length of the benefit from 6 to 13 weeks; and
- Provide access to the benefit during times of medical crisis, and not only during the palliative stages of illness.

Furthermore, the federal government must promote awareness of the compassionate care benefit among all Canadians.

- 24. That the federal government work collaboratively with the provinces and territories, policy-makers, stakeholders and family caregivers to establish a National Caregiving Strategy. The Strategy should form a part of a larger federal integrated care initiative.
- 25. That the federal government work with the voluntary sector to identify mechanisms to recognize and reimburse the out-of-pocket expenses incurred by volunteers, particularly in activities funded through federal grants and contributions.
- 26. That the needs of the voluntary sector be the subject of further study, either by a Senate Committee or by an Expert Panel, in order to examine:
- The emerging challenges of recruiting and retaining volunteers;
- o Options to promote volunteerism; and
- The role of the federal government in supporting the capacity of the voluntary sector throughout the country, including the use of multi—year funding arrangements and the implications of introducing a tax credit for volunteering.
- 27. That the federal government support education and outreach campaigns promoting geriatric and gerontological health care professions as career choices, including the funding of residency positions in geriatrics.

- 28. That the federal government work with the provinces and territories to address the training, recruitment and retention of home care and home support workers as part of the FPT Health Human Resource Strategy.
- 29. That the federal government support and invest in the expanded use of telemedicine and telehomecare through a transition fund for provinces, a home technology fund for home and community care organizations, and by improving technology use in the direct provision of services to its client groups, including ensuring internet connectivity in northern and remote communities, and that Canada's official-language minority communities be consulted in the development of such an initiative.
- 30. That the federal government adopt the integrated service approach recommended by the Gerontological Advisory Council to Veterans Affairs Canada and begin by expanding the eligibility for programs at Veterans Affairs Canada to all surviving war service veterans, not just to clients of the department.
- 31. That the federal government address the needs of First Nations and Inuit seniors and their communities, including the need for:
- More and improved housing;
- Increased attention to safe drinking water, diet, foot care and other diabetic needs;
- Measures to ensure wage parity among providers;
- Increased home care and hospice palliative care services;
- More support for informal caregivers;
- The removal of the funding cap for the Non-Insured Health Benefits Program; and
- o Measures to fully integrate the range of programs currently available to seniors on First Nations reserves and in Inuit communities into a seamless system comparable to that employed by Veterans Affairs Canada.
- 32. That, pursuant to its role under the Official Languages Act, the federal government establish effective interdepartmental collaboration on official language minority seniors that includes

participation by seniors in advisory groups and continue to earn federal funds for the development of new models of service delifor these official language minority seniors.								

Appendix III: Checklist of Essential Features of Age-friendly Cities





Checklist of Essential Features of Age-friendly Cities

This checklist of essential age-friendly city features is based on the results of the WHO Global Age-Friendly Cities project consultation in 33 cities in 22 countries. The checklist is a tool for a city's self-assessment and a map for charting progress. More detailed checklists of age-friendly city features are to be found in the WHO Global Age-Friendly Cities Guide.

This checklist is intended to be used by individuals and groups interested in making their city more age-friendly. For the checklist to be effective, older people must be involved as full partners. In assessing a city's strengths and deficiencies, older people will describe how the checklist of features matches their own experience of the city's positive characteristics and barriers. They should play a role in suggesting changes and in implementing and monitoring improvements.

Outdoor spaces and buildings	$\hfill \square$ Services are situated together and are
☐ Public areas are clean and pleasant.	accessible.
 Green spaces and outdoor seating are sufficient in number, well-maintained and safe. 	 Special customer service arrangements are provided, such as separate queues or service counters for older people.
 Pavements are well-maintained, free of obstructions and reserved for pedestria 	☐ Buildings are well-signed outside and inside, with sufficient seating and toilets, accessible elevators, ramps, railings and
☐ Pavements are non-slip, are wide enoug	
for wheelchairs and have dropped curbs road level.	□ Public toilets outdoors and indoors are sufficient in number, clean, well-main-
 Pedestrian crossings are sufficient in number and safe for people with different 	tained and accessible.
levels and types of disability, with non- slip markings, visual and audio cues and	Transportation
adequate crossing times.	 Public transportation costs are consistent, clearly displayed and affordable.
 Drivers give way to pedestrians at inters tions and pedestrian crossings. 	 Public transportation is reliable and fre-
 Cycle paths are separate from pavement and other pedestrian walkways. 	quent, including at night and on weekends and holidays.
and other pedestrian warkways.	☐ All city areas and services are accessible by
 Outdoor safety is promoted by good struighting, police patrols and community 	

APPENDIX III: CHECKLIST OF ESSENTIAL FEATURES OF AGE-FRIENDLY CITIES

	Vehicles are clean, well-maintained, acces-	Housing
	sible, not overcrowded and have priority seating that is respected.	☐ Sufficient, affordable housing is available in areas that are safe and close to services
	Specialized transportation is available for	and the rest of the community.
	disabled people.	□ Sufficient and affordable home mainte-
	Drivers stop at designated stops and beside	nance and support services are available.
	the curb to facilitate boarding and wait for passengers to be seated before driving off.	☐ Housing is well-constructed and provides safe and comfortable shelter from the
	Transport stops and stations are conve-	weather.
	niently located, accessible, safe, clean, well- lit and well-marked, with adequate seating and shelter.	 Interior spaces and level surfaces allow freedom of movement in all rooms and passageways.
	Complete and accessible information is provided to users about routes, schedules and special needs facilities.	 Home modification options and supplies are available and affordable, and providers understand the needs of older people.
	A voluntary transport service is available where public transportation is too limited.	☐ Public and commercial rental housing is clean, well-maintained and safe.
	Taxis are accessible and affordable, and drivers are courteous and helpful.	☐ Sufficient and affordable housing for frail and disabled older people, with appropri-
	Roads are well-maintained, with covered	ate services, is provided locally.
	drains and good lighting.	Social participation
	Traffic flow is well-regulated.	☐ Venues for events and activities are con-
	Roadways are free of obstructions that block drivers' vision.	veniently located, accessible, well-lit and easily reached by public transport.
	Traffic signs and intersections are visible and well-placed.	 Events are held at times convenient for older people.
	Driver education and refresher courses are promoted for all drivers.	☐ Activities and events can be attended alone or with a companion.
	Parking and drop-off areas are safe, sufficient in number and conveniently located.	 Activities and attractions are affordable, with no hidden or additional participa- tion costs.
	Priority parking and drop-off spots for people with special needs are available and respected.	The second secon

APPENDIX III: CHECKLIST OF ESSENTIAL FEATURES OF AGE-FRIENDLY CITIES

 □ The qualities of older employees are well-promoted. □ A range of flexible and appropriately paid opportunities for older people to work is promoted. □ Discrimination on the basis of age alone is forbidden in the hiring, retention, promotion and training of employees. □ Workplaces are adapted to meet the needs of disabled people.
□ Self-employment options for older people are promoted and supported. □ Training in post-retirement options is provided for older workers. □ Decision-making bodies in public, private and voluntary sectors encourage and facilitate membership of older people. Communication and information □ A basic, effective communication system reaches community residents of all ages. □ Regular and widespread distribution of

APPENDIX III: CHECKLIST OF ESSENTIAL FEATURES OF AGE-**FRIENDLY CITIES**

	 Regular information and broadcasts of interest to older people are offered. 	Community and health services			
	Oral communication accessible to older people is promoted.	 An adequate range of health and commu- nity support services is offered for promot- ing, maintaining and restoring health. 			
	☐ People at risk of social isolation get one-to- one information from trusted individuals.	☐ Home care services include health and personal care and housekeeping.			
	☐ Public and commercial services provide friendly, person-to-person service on request.	☐ Health and social services are conveniently located and accessible by all means of transport.			
	☐ Printed information — including official forms, television captions and text on visual displays — has large lettering and the	 Residential care facilities and designated older people's housing are located close to services and the rest of the community. 			
	main ideas are shown by clear headings and bold-face type.	☐ Health and community service facilities are safely constructed and fully accessible.			
	 Print and spoken communication uses simple, familiar words in short, straight- forward sentences. 	 Clear and accessible information is pro- vided about health and social services for older people. 			
	☐ Telephone answering services give in- structions slowly and clearly and tell call- ers how to repeat the message at any time.	☐ Delivery of services is coordinated and administratively simple.			
	☐ Electronic equipment, such as mobile telephones, radios, televisions, and bank	☐ All staff are respectful, helpful and trained to serve older people.			
	and ticket machines, has large buttons and big lettering.	 Economic barriers impeding access to health and community support services are minimized. 			
	 There is wide public access to computers and the Internet, at no or minimal charge, in public places such as government of- 	☐ Voluntary services by people of all ages are encouraged and supported.			
	fices, community centres and libraries.	☐ There are sufficient and accessible burial sites.			
		 Community emergency planning takes into account the vulnerabilities and ca- pacities of older people. 			
	WHO/FCH/ALC/2007.1 © World Health Organization 2007. All right	s reserved.			
AGE 4					
	World Health Organization, no.int/ageing/publications/Age_friendly_cities	_checklist.pdf.			

Appendix IV: List of Witnesses Second Session Thirty-ninth Parliament

November 26, 2007

Human Resources and Social Development Canada

Shawn Tupper, Director General, Social Policy Development; Dominique La Salle, Director General, Seniors and Pensions Policy Secretariat;

Roman Habtu, OAS Benefits Policy.

Department of Finance Canada

Frank Vermaeten, Director General, Assistant Deputy Minister's Office;

Krista Campbell, Senior Chief, Federal-Provincial Relations Division;

Andrew Staples, Acting Chief, Federal-Provincial Relations Division.

December 3, 2007

Canadian Institute for Health Information

Jean-Marie Berthelot, Vice-President, Programs; Christopher Kuchciak, Program Leads, NHEX/OECD.

Canadian Centre for Policy Alternatives

Marc Lee, Senior Economist.

As an individual

Robert Evans, Professor of Economics, University of British Columbia.

Joe Ruggeri, Professor of Economics, University of New Brunswick.

Public Health Agency of Canada

Margaret Gillis, Director, Division of Aging and Seniors/Office of Voluntary Sector.

December 10, 2007

Canada Mortgage and Housing Corporation

Luis Rodriguez, Senior Researcher;

Debra Darke, Director, Community Development.

Canadian Healthcare Association

Sharon Sholzberg-Gray, President and Chief Executive Officer.

The Royal Canadian Legion

Pierre Allard, Director, Service Bureau;

David MacDonald, Consultant, Legion Housing Centre for Excellence.

As individuals

Marcus J. Hollander, President, Hollander Analytical Services Ltd. Margaret Isabel Hall, Assistant Professor, Law Faculty, University of British Columbia.

January 28, 2008

Canadian Automobile Association

David M. Munroe, Chair of the Board CAA National; Christopher White, Vice-President, Public Affairs.

Canadian Medical Association

Dr. Briane Scharfstein, Associate Secretary General, Professional Affairs.

Lakehead University

Dr. Michel Bédard, Canada Research Chair in Aging and Health.

The Rehabilitation Centre, Ottawa Hospital

Dr. Shawn Marshall, Associate Professor.

Canadian Centre for Elder Law Studies

Laura Watts, National Director.

Alzheimer Society of Nova Scotia

Jeanne Desveaux, President.

February 4, 2008

Correctional Service of Canada

Ross Toller, Assistant Commissioner, Correctional Operations and Programs;

Leslie MacLean, Assistant Commissioner, Health Services.

Office of the Correctional Investigator

Ed McIsaac, Executive Director;

Howard Sapers, Correctional Investigator.

Canadian Association of Elizabeth Fry

Kim Pate, Executive Director.

Insurance Bureau of Canada

Mark Yakabuski, President and Chief Executive Officer.

Federation of Medical Regulatory Authorities of Canada

Fleur-Ange Lefebvre, Executive Director and Chief Executive Officer.

February 11, 2008

Statistics Canada

René Morissette, Assistant Director, Research Business and Labour Market Analysis Division;

Garnett Picot, Director General, Socio-Economic and Business Analysis;

Ted Wannell, Assistant Director, Labour and Household Analysis Division.

As individuals

John Myles, Canada Research Chair and Professor of Sociology, University of Toronto.

Derek Hum, Professor of Sociology, University of Manitoba.

Human Resources and Social Development Canada

Maxime Fougère, Assistant Director, Labour Market Research and Forecasting.

Informetrica Limited

Richard Shillington, Senior Associate.

Women Elders in Action

Alice West, Chair; Elsie Dean, Researcher; Jan Westlund, Coordinator.

April 7, 2008

Université de Montréal

Dr. François Béland, Full Professor.

Health Council of Canada

Donald Juzwishin, Chief Executive Officer.

Canadian Hospice Palliative Care Association

Sharon Baxter, Executive Director.

Canadian Institutes of Health Research

Anne Martin-Matthews, Scientific Director, Institute of Aging.

As an individual

Marcus J. Hollander, President, Hollander Analytical Services Ltd.

Alzheimer Society of Canada

Patricia Wilkinson, Manager, Media and Government Relations; Betty Brousse, Volunteer.

April 14, 2008

Queen's University

Kathleen Lahey, Law Professor.

Federal Superannuates National Association

Francis Bowkett, Executive Director;

Bernard Dussault, Senior Research and Communications Officer.

McMaster University

Michael Veall, Professor and Chair, Department of Economics.

Informetrica Ltd.

Bob Baldwin, Senior Associate.

As an individual

Kevin Milligan, Assistant Professor of Economics, University of British Columbia.

April 28, 2008

As individuals

Donald Paterson, Professor, School of Kinesiology, Faculty of Health Sciences, University of Western Ontario. Elaine Gallagher, Director, Centre on Aging, University of Victoria.

Alberta Centre for Active Living Chad Witcher, Representative.

Canadian Urban Institute

Glenn Miller, Director, Education and Research.

Seniors College of Prince Edward Island Ian Scott, President.

Volunteer Canada

Ruth MacKenzie, President.

May 5, 2008

As individuals

Joe Ruggeri, Professor, Department of Economics, University of New Brunswick.

Byron Spencer, Professor of Economics, McMaster University.

Canadian Centre for Policy Alternatives Marc Lee, Senior Economist.

May 9, 2008

Regional Municipality of Niagara Community Services Department Carol Rudel, Manager, Seniors Community Programs; Dominic Ventresca, Director of Seniors Services.

Hamilton Niagara Haldimand Brant Community Care Access Centre Tom Peirce, Senior Director, Strategic Planning and Integration.

Ontario Network for the Prevention of Elder Abuse
Maureen Etkin, Regional Consultant, Central West;
Gail MacKenzie-High, Chair, Niagara Elder Abuse Prevention Network.

- Alzheimer's Society of Niagara Region
 Marge Dempsey, Acting Chief Executive Officer.
- Ontario Home Care Association
 Susan D. VanderBent, Executive Director.
- Hamilton Council on Aging
 Denise O'Connor, Executive Director;
 Carolyn Rosenthal, Chair, Board of Directors.
- Community Support Services of Niagara Wendy Walker, Executive Director; Patricia Tooley, Program Manager; Pat Frank, Chair, Board of Directors.
- Niagara Health System
 Wendy Robb, Health Program Director, Port Colborne Site.
- Older Women's Network
 Thelma McGillivray, Past Chair.
- Canadian Pensioners Concerned Incorporated Christine Mounsteven, President, Ontario Division; Sylvia Hall, Secretary/Treasurer, Ontario Division.
- Rose City Seniors Activity Centre John Rose, Vice-Chair.
- Welland Accessibility Advisory Committee Russ Findlay, Chair.
- Senior Citizens Advisory Committee to the City of Welland Doug Rapelje, Representative.
- Francophone Community Health Centre Hamilton/Niagara Marcel Castonguay, Director General.
- Foyer Richelieu André Tremblay, Director General.
- As an individual Gary Atamanyk.
- Centre polyvalent des aînés francophones de Port Colborne Roland Méthot, Chair.

VON Canada

Marlene Slepkov, Interim Branch Manager.

As an individual

Ron Walker.

May 12, 2008

Nova Scotia Centre on Aging

Pamela Fancey, Associate Director/Research Associate, Mount Saint Vincent University.

Spencer House Seniors' Centre

Deborah Dostal, Executive Director.

Community Links

Sandra Murphy, Executive Director.

As individuals

Dr. David Martell, Lunenburg Medical Centre.

Dr. Chris MacKnight, Associate Professor, Department of Medicine, Dalhousie University.

Dr. Ken Rockwood, Professor of Geriatric Medicine, Dalhousie University.

Department of Finance, Government of Nova Scotia Elizabeth Cody, Assistant Deputy Minister.

As individuals

David Ward, Member, Acadia Lifelong Learning.

G. A. Trudy Ward, Member, Acadia Lifelong Learning.

Linda MacDonald, Elder Learners, Saint Mary's University.

May 13, 2008

New Brunswick Senior Citizens' Federation Ralph Smith, President.

Coalition for Seniors and Home Residents' Rights of New Brunswick Hector Cormier, President;

Cecile Cassista, Executive Director.

Association acadienne et francophone des aînées et aînés du Nouveau-Brunswick

Jean-Luc Bélanger, Chair.

The Royal Canadian Legion, New Brunswick Command Dennis Driscoll, Chair, Veterans and Seniors Committee.

Health Canada

Debra Keays-White, Regional Director, First Nations and Inuit Health Branch, Atlantic Region;

Peter McGregor, Special Advisor, First Nations and Inuit Health Branch, Home and Community Care;

Wade Were, Acting Senior Advisor, First Nations and Inuit Health Branch, Policy and Strategic Planning.

Prince Edward Island Seniors' Secretariat Faye Martin, Acting Director;

Anna Duffy, Co-Chair.

May 16, 2008

As individuals

Dr. Réjean Hébert, Dean, Faculty of Medicine and Health Sciences, University of Sherbrooke.

Dr. Hélène Payette, Professor, Department of Community Health Sciences, Faculty of Medicine and Health Sciences, University of Sherbrooke.

Centre for Research on Aging

Dr. Stephen Cunnane, Director.

Association estrienne pour l'information et la formation aux aînées et aînés (AEIFA)

Sylvie Morin, Coordinator.

Agence Continuum Inc.

Hélène Gravel, Chair.

Quebec Elders' Council

William Murray, Research Officer.

Table régionale de concertation des aînées et des retraités de l'Estrie Paul Rodrigue, Treasurer; Jacques Demers, Secretary.

University of Third Age Gilles Beaulieu, Development Officer.

As individuals

Marie Beaulieu, Professor, Social Services, University of Sherbrooke. Monique Joyal-Painchaud. Gilles Grenier. André Fréchette.

June 2, 2008

Villa Youville Jean Balcaen, President.

South Eastman Health
Aurèle Boisvert, President.

Centre Taché and Foyer Valade Charles Gagné, Director General.

Conseil communauté en santé du Manitoba Annie Bédard, Executive Director.

Fédération des aînés franco-manitobains Inc. Thérèse Dorge, President; Gérald Curé, Director General.

As individuals

Dr. Gérald Gobeil. Louis Bernardin.

Health Canada

Jim Wolfe, Regional Director, Manitoba.

Aboriginal Seniors Resource Centre (Winnipeg)
Thelma Meade, Executive Director.

Indian & Metis Friendship Centre of Winnipeg Dennis Sinclair, Program Manager.

Menno Home for the Aged
Maria Krentz, Acting Administrator.

Steinbach 55 Plus.

Pat Porter, President;

Dianna White, Executive Director.

Club de l'Amitié

Paulette Sabot, Treasurer.

Rest Haven Nursing Home

Tannis Nickel, Director, Nursing Services.

South Eastman Health

Sylvia Nilsson-Barkman, Services to Seniors Program Specialist.

June 4, 2008

411 Seniors Centre Society

Margaret Coates, Executive Director.

Providence Health Care

Dr. Sharon Koehn, Research Associate, Centre for Healthy Aging.

As an individual

Eunju Hwang, B.C. Real Estate Foundation Fellow, Simon Fraser University's Gerontology Research Centre.

MOSAIC

Eyob G. Naizghi, Executive Director.

Progressive Intercultural Community Services Society Charan Gill, Chief Executive Officer.

Charan Gill, Chief Executi

S.U.C.C.E.S.S.

Alice Choi, Administrator.

Collingwood Neighbourhood House

Jo-Anne Stephens, Seniors Program Coordinator.

BC Centre for Elder Advocacy and Support

Penny Bain, Secretary and Director, Board of Directors.

Canadian Network for the Prevention of Elder Abuse

Charmaine Spencer, member of the board.

First Nations Health Council

Joe Gallagher (Kwunahmen), Senior Director.

BC Association of Aboriginal Friendship Centres Lisa Mercure, Elders Coordinator.

As individuals

Gregg Schiller, Coordinator, BC Seniors Advocacy Network. Bonnie O'Sullivan, Social Coordinator, 411 Seniors Centre Society.

Joanne Taylor, Executive Director, Nidus Personal Planning Resource Centre and Registry. Steve Ellis.

June 5, 2008

Council of Senior Citizens' Organizations of British Columbia Gudrun Langolf, Director.

B.C. Retired Teachers' Association

Cliff Boldt, Director;

Reg Miller, Member of the Advocacy Committee.

Family Caregivers' Network Society Barbara MacLean, Executive Director.

BC Seniors Living Association Seona Stephen, Vice President.

Vancouver Island Health Authority

Dr. Michael Cooper, Division Head of Geriatric Psychiatry; Dr. Marianne McLennan, Director, Seniors, End of Life and Spiritual Health.

Saanich Peninsula Health Association Lyne England, Chair.

As individuals

Carol Pickup, South Island Health Coalition.

Judith Cameron, Executive Director, Fairfield Activity Centre.

Dale Perkins, Minister, United Church of Canada, Victoria

Presbytery.

Elfreda Schneider.

Judith Johnson.

BC Medical Association

Dr. Duncan Robertson, Geriatrics and Palliative Care.

June 9, 2008

National Seniors Council Jean-Guy Soulière, Chair.

International Federation on Ageing
Jane Barratt, Secretary General.

National Pensioners and Seniors Citizens Federation Joyce Mitchell, Treasurer.

First Session Thirty-ninth Parliament

November 27, 2006

Statistics Canada

Pamela White, Director, Demography Division; Laurent Martel, Analyst, Research and Analysis Section.

As an individual

Byron Spencer, Professor, Economics, McMaster University.

National Aboriginal Health Organization

Carole Lafontaine, Acting CEO; Mark Buell, Manager, Policy Communication Unit.

National Advisory Council on Aging

Robert Dobie, Acting Chair;

Margaret Gillis, Director, Division of Aging and Seniors, Centre for Healthy Human Development, Public Health Agency of Canada.

As an individual

Douglas Durst, Professor, Faculty of Social Work, University of Regina.

December 4, 2006

Human Resources and Social Development Canada

Peter Hicks, Executive Director, Strategic Analysis, Audit and Evaluation;

John Connolly, Director, Partnerships Division, Community Development and Partnerships Directorate;

Marla Israel, Director, International Policy and Agreements, Seniors and Pensions Policy Secretariat.

Public Health Agency of Canada

Margaret Gillis, Director, Division of Aging and Seniors, Centre for Healthy Human Development.

Health Canada, First Nations and Inuit Health Branch Leslie MacLean, Director General, Non-Insured Health Benefits; Shelagh Jane Woods, Director General, Primary Health Care and Public Health Directorate.

Indian and Northern Affairs Canada

Havelin Anand, Director General, Social Policy and Programs Branch.

Veterans Affairs Canada

Bryson Guptill, Director General, Program and Service Policy Division.

Canada Mortgage and Housing Corporation Douglas Stewart, Vice President, Policy and Planning.

Treasury Board of Canada Secretariat

Dan Danagher, Executive Director, Labour Relations and Compensation Operations.

Public Service Human Resources Management Agency of Canada Cecilia Muir, Director General, Public Service Renewal and Diversity.

December 11, 2006

Canadian Association for the Fifty-plus, CARP
Judy Cutler, Director of Government Relations;
Taylor Alexander, Consultant in Aging Policy and Continuing
Care.

Royal Canadian Legion

Jack Frost, Dominion President; Pierre Allard, Director, Service Bureau.

International Federation on Ageing

Jane Barratt, Secretary General.

Canadian Institutes of Health Research
Anne Martin-Matthews, Scientific Director, Institute of Aging.

Canadian Association on Gerontology Sandra P. Hirst, President.

National Initiative for the Care of the Elderly Lynn McDonald, Scientific Director.

February 12, 2007

Human Resources and Social Development Canada Peter Hicks, Executive Director, Strategic Analysis, Audit and Evaluation.

February 19, 2007

As individuals

Victor Marshall, Professor of Sociology, Institute on Aging, University of North Carolina. Susan Kirkland, Professor, Canadian Longitudinal Study on Aging, Dalhousie University.

Policy Research Initiative

Terrence Hunsley, Senior Project Director.

Statistics Canada

Geoff Rowe, Senior Advisor - Microsimulation.

March 19, 2007

As individuals

Jacques Légaré, Professor Emeritus of Demography, Université de Montréal.

Marchel Mérette, Associate Professor of Economics, University of Ottawa.

Neena L. Chappell, Canada Research Chair in Social Gerontology and Professor of Sociology, Centre on Aging, University of Victoria.

Gloria Gutman, Professor, Gerontology, Simon Fraser University, and Director, Dr. Tong Louie Living Laboratory.

March 26, 2007

Statistics Canada

Leroy Stone, Associate Director General, Unpaid Work Analysis; Danielle Zietsma, Senior Economist, Labour Statistics Division.

Conference Board of Canada

Paul Darby, Deputy Chief Economist.

Certified General Accountants Association of Canada

Rock Lefebvre, Vice-President, Research and Standards.

As individuals

Derwyn Sangster, former Director, Business, Canadian Labour and Business Centre.

Brigid Hayes, former Director, Labour, Canadian Labour and Business Centre.

Monica Townson, Economic Consultant.

May 7, 2007

International Federation on Ageing

Jane Barratt, Secretary General.

Organisation for Economic Co-operation and Development

Monika Queisser, Expert on Demographic Ageing, Employment, Labour and Social Affairs Directorate.

Healthy Ageing Project

Karin Berensson, Project Manager;

Barbro Westerholm, MP (Sweden) and participant of the Healthy Ageing project.

Active Living Coalition for Older Adults

Dianne Austin, National Executive Director.

Creative Retirement Manitoba

Marjorie Wood, Executive Manager.

International Council on Active Aging

Colin Milner, Chief Executive Officer.

May 14, 2007

Assembly of First Nations
Elmer Courchene, Elder;
Richard Jock, Chief Executive Officer.

Métis National Council

Don Fiddler, Senior Policy Advisor.

Inuit Tapiriit Kanatami Okalik, Eegeesiak, Director, Socio-Economic Development; Jennifer Forsyth, Health Technical Advisor;

Pauktuutit Inuit Women of Canada Jennifer Dickson, Executive Director.

Maria Wilson, Project Coordinator.

National Association of Native Friendship Centres Peter Dinsdale, Executive Director; Alfred Gay, Policy Analyst.

Aboriginal Seniors Resource Centre of Winnipeg Thelma Meade, Executive Director.

May 28, 2007

Alzheimer Society of Canada Dale Goldhawk, Chairman of the Board; Scott Dudgeon, Chief Executive Officer.

Advocacy Centre for the Elderly
Judith A. Wahl. Executive Director.

Canadian Coalition for Senior's Mental Health Faith Malach, Executive Director.

Canadian Ethnocultural Council
Anna Chiappa, Executive Director.

Fédération des aînées et aînés francophones du Canada Jean-Luc Racine, Executive Director.

Canadian Network for the Prevention of Elder Abuse Alison Leaney, Chair of the Board; Charmaine Spencer, Member of the Board.

June 4, 2007

The Honourable Marjory LeBreton, P.C., Leader of the Government in the Senate and Secretary of State (Seniors).

National Senior Council

Jean-Guy Soulière, Chair.

Human Resources and Social Development Canada Susan Scotti, Senior Assistant Deputy Minister, Income Security

and Social Development.

Conférence des Tables régionales de concertation des aînés du Québec Jean-Guy Saint-Gelais, Secretary and former Chair.

June 11, 2007

As an individual

Janice M. Keefe, Canada Research Chair in Aging and Caregiving Policy and Director, Nova Scotia Centre on Aging, Mount Saint Vincent University.

Canadian Caregiver Coalition

Palmier Stevenson-Young, President.

Group of IX

Bernie LaRusic, Vice Chairperson.

As an individual

Judy Lynn Richards, Assistant Professor, Department of Sociology and Anthropology, University of Prince Edward Island.

June 18, 2007

Canadian Hospice Palliative Care

Sharon Baxter, Executive Director; Dr. Lawrence Librach, Vice-President.

Pallium Project

Michael Aherne, Director, Initiative Development.

Canadian Home Care Association

Nadine Henningsen, Executive Director.

Appendix V: Costs: Community versus Facility

Caregivers, and Total Societal Costs, for Community and Facility Clients 236

	Care Levels (based on SMAF Scores)	Costs to Government	Other Health Related Costs	Total Costs to Government	Out of Pocket Expenses for Clients and/or Caregivers	Imputed C Caregiver Time at Minimum Wage	Caregiver Costs Caregiver Time at Replacement Wage	Total Costs to Clients and/or Caregivers	Total Societal Costs
Community	Level 1&2	3,800	1,037	4,837	1,040	3,703	13,371	14,411	19,248
	Level 3	5,388	743	5,905	2,493	5,000	17,701	20,194	26,099
	Level 4	11,122	1,661	12,783	1,915	7,985	29,168	31,083	43,866
	Level 5	14,120	755	14,875	3,848	12,877	46,449	50,297	65,172
	Level 6&Up	11,878	2,702	14,581	1,289	11,207	40,974	42,263	56,844
	Overall Average	7,963	1,209	9,104	2,144	7,134	25,760	27,904	37,008
Facility	Level 4	62,576	432	63,008	12,443	3,400	11,796	24,239	87,247
	Level 5	62,576	5,099	67,675	14,536	2,620	9,081	23,617	91,292
	Level 6	62,576	2,018	64,594	12,630	3,347	11,833	24,463	89,057
	Level 7	62,576	2,235	64,811	11,726	3,495	12,249	23,975	88,786
	Level 8	62,576	2,720	65,296	12,731	1,812	6,322	19,053	84,349
	Level 9	62,576	1,627	64,203	11,395	2,196	7,725	19,120	83,323
	Overall Average	62,576	2,599	65,175	12,495	2,772	9,706	22,201	87,376

Miller, Jo Ann, Marcus Hollander, Margaret MacAdam The Continuing Care Research Project for Canada and the Government of Ontario: Synthesis Report April 2008, p. 29.