

**Special Senate Committee on Aging
Second Interim Report**

**Issues and Options for an Aging
Population**

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

March 2008

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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 Céline Hervieux-Payette, P.C., (or Claudette Tardif)
and Marjory LeBreton, P.C., (or Gérald Comeau)

In addition, the honourable Senators Joan Cook, Janis G. Johnson
and Lowell Murray, P.C., also participated in the committees
deliberations.

Analysts from the Parliamentary Information and Research
Services, Library of Parliament:

Julie Cool
Michael Toye
Havi Echenberg
Michael Holden
Philippe Le Goff

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 Thursday, November 1, 2007:

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

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

That, pursuant to rule 85(1)(b), the committee be comprised of seven members, to be nominated by the Committee of Selection 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;

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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 Session of the Thirty-ninth Parliament be referred to the Committee;

That the Committee submit its final report no later than June 30, 2008, and that the Committee retain all powers necessary to publicize its findings until 90 days after the tabling of the final report;

And on the motion in amendment of the Honourable Senator Comeau, seconded by the Honourable Senator Tkachuk, that the motion be amended by replacing the words "June 30, 2008" with "March 31, 2008" in the last paragraph.

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

Extract from the *Journals of the Senate* of Thursday, February 28, 2008:

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

That, notwithstanding the order of the Senate adopted on November 1, 2007, the date for the presentation of the final report by the Special Senate Committee on Aging on the implications of an aging society in Canada be extended from March 31, 2008, to September 30, 2008 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

Chapter 1: Introduction

1.1 Overview of the Committee's Work

In November 2006, the Special Senate Committee on Aging was created with a broad mandate to review a wide range of complex issues, ranging from financial security and retirement to chronic diseases and palliative care, to determine if we are providing the right programs and services at the right time to the individuals who need them. By examining these issues through a public health lens, the Committee will review public programs and services for seniors, identify the gaps that exist in meeting their needs, and examine 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 the 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 questions 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.

This interim report is the result of the Committee's work during the second phase. In this report, the Committee identifies key public policy issues with respect to the aging of the population and presents a set of potential options for addressing them. The issues and options contained in this report have been raised by witnesses before the Committee and in responses to the questionnaire; however, there may be other valid options which have not yet come to light.

In the next, and final, phase of its study, the Committee intends to invite expert witnesses to testify at roundtable hearings and to travel throughout Canada to hear from Canadians on the issues and options to develop a comprehensive set of final recommendations.

Some preliminary observations on the four broad questions which guided phase two deliberations are outlined below. These questions will be explored in depth in the final report.

1.2 Defining Seniors

The Committee's first interim report identified three broad age categories which distinguished seniors: the "young old" who are healthy, fit and reasonably affluent; the "middle old" who are starting to slow down and have less money and resources; and the "frail old" who are very elderly and have special social and physical needs. Other witnesses have suggested that there are four phases of life - "youth, adulthood, and a new "golden age" which extends from retirement to old age, and old age, which has essentially been pushed back."¹ Chronological age as the defining marker of being old is being eroded. Competency is increasingly replacing age as a more appropriate benchmark for behaviour or rights. At the same time, old age is being defined by loss of independence or by ill health.

Loss of independence and ill health are not the exclusive domain of seniors. They can be experienced in a temporary or permanent way by Canadians at any stage of life. Therefore, programs and policies to maximize independence and health are not only "seniors issues", but can potentially benefit all Canadians. We recognize that some older seniors face mobility and housing challenges; however, accommodations to make age-friendly cities will force society to embrace the long-held dictum that we are all only temporarily able-bodied. Similarly, addressing the myriad of challenges that the final years of life present to individuals, their families, and the health and social systems will benefit all Canadians, whether those final years occur in their youth, middle years, or as seniors.

It is quite likely that the baby-boom generation will redefine the senior years and retirement. Young seniors are generally healthier and wealthier than previous generations of seniors. Seniors today are living healthy, active lives. They are increasingly active in the labour force. Senior volunteers volunteer many more hours than their younger counterparts.

In its first interim report, the Committee raised questions about revisiting the age of eligibility for seniors' programs in light of the increase in the healthy life expectancy of most Canadians. The majority of witnesses who responded to this question cautioned that moving the age of eligibility upward would have a disproportionately negative impact on the most vulnerable groups of seniors, without significant change to the behaviour of higher-income seniors. As the

¹ Jacques Légaré, Professor Emeritus of Demography, Université de Montréal, Evidence, March 19, 2007.

following chapters will demonstrate, a more promising policy approach might be to empower the aging population to “contribute as it would if uninhibited by disincentives and competing policy priorities; all the while affording the health and social services that we, as a nation, require.”²

1.3 The Diversity of Seniors

The evidence heard by the Committee during its meetings, and the responses received to the questionnaires sent to seniors organizations throughout the country have led the Committee to appreciate that, like all other age groups, seniors form a very diverse group with a wide range of expectations, needs and interests.

The first interim report described significant gaps in health outcomes and life expectancy between Aboriginal Canadians and non-Aboriginal Canadians. There are also disparities between immigrant and non-immigrant seniors. As the countries of origin for immigration have shifted over time (reduced numbers from Europe and the United States and increased numbers from Asia and the Middle East), so too is this diversity reflected in the 65-74 year old population. The percentage of immigrant seniors that speak neither official language has risen over time, from 4% of those who arrived before 1961 to 50% of those who arrived between 1991 and 2001. These differences will require change in the way services and programs are delivered to seniors.

Along with the diversity within the senior population, there are differences between regions in the potential impact of population aging. The implications of these differences are elaborated in Chapter 6.

As the Committee elicits feedback on the issues and options outlined in this interim report, it will ask Canadians to reflect on whether the options presented reflect the diverse needs, circumstances and aspirations of all Canadians.

² Certified General Accounts, The Certified General Accountants Association of Canada Statement delivered before the Special Senate Committee on Aging, March 26, 2007, p.4.

1.4 Policy Approaches

In its first interim report, the Committee set out to examine the challenge of moving toward a policy framework which could more adequately spread productive work over the full course of life and give older Canadians the opportunities to be active, creative and thriving participants in society. The Committee has heard that:

Policy discussions of aging can refer to two quite different topics. One topic is individual aging. Here the focus is on policies that relate to older people. We discuss issues such as the adequacy of pension income, the active engagement of seniors in the life of the community, and how policy supports the transitions – often near the end of life – to frailty and disability. The other topic is population aging, where the focus is on the policy implications of the changing age structure and size of the population. Discussions here tend to focus on the fiscal consequences of population aging, the social and economic effects of an older workforce and of changes in the ratio of consumers to producers, issues related to lifelong learning and to the timing and gradualness of transitions to retirement.³

The terms of reference for the Committee fit more neatly within the first set of questions. The issues and options outlined in this interim report reflect, however, that addressing issues relating to older persons opens up options to reconsider the way that life transitions are accommodated throughout the life course. This is particularly relevant to the chapters on aging in place of choice, active aging, and work and retirement.

The issues and options outlined in this interim report also reflect that aging is a life-long process, and that some of the options to improve health and well-being among seniors need to be implemented throughout each stage of life, and not only in the senior years.

³ Brief: *Appearance before the Special Senate Committee on Aging*. Peter Hicks, Executive Director, Strategic Analysis, Audit and Evaluation, HRSDC. February 12, 2007, p.1.

1.5 Federal Government Role

When the provincial, territorial, and federal governments set out to develop a national framework on aging in the late 1990s, they consulted with seniors on the key values which should underpin this framework. The Committee has heard that these values - dignity, independence, participation, fairness and security – continue to be relevant today. These values will form the foundation for the issues and options considered by the Committee in this report.

In trying to determine the appropriate role of all levels of governments, a recurring theme presented to the Committee has been the maintenance of choice – choice in when to retire, choice in where to live. The Committee recognizes the important role of individuals, non-profit organizations, the private sector, and the various levels of government in ensuring that seniors have before them a wide range of choices. The Committee has heard that the range of choices is greatest for those with the greatest financial security, and more limited for low-income seniors; greater in urban areas than in rural. The range of options also differs among population groups under the responsibility of the federal government, with a wider range of options for veterans than First Nations and Inuit seniors.

Many of the programs and services for older Canadians are delivered by provincial and territorial governments. Some of the options proposed in this interim report reflect the role the Canadian government can play in facilitating the exchange of information and best practices across jurisdictions. Other options are clearly addressing federal programs and areas of jurisdictions.

The federal government provides direct health care services to certain population groups for which it has a mandate (First Nations and Inuit people). The federal government also provides health services to eligible veterans, refugee protection claimants and inmates of federal penitentiaries. As it moves toward its final report, the Committee will want to consider carefully the programs and policies for these population groups. The credibility of the federal government in the area of services to seniors depends, in no small part, on the leadership role it could play in meeting the needs of groups under its own direct responsibility. This will be explored in greater depth in the Committee's final report.

1.6 Organization of This Report

This interim report is organized into issue-specific chapters relating to: active aging; older workers, retirement and income security; healthy aging; supports to aging in place of choice; and the regional distribution of health costs associated with aging. Several policy options are proposed to address the issues raised in each chapter. Some of these policy options are complementary, others mutually exclusive. As the Committee wraps up its study, it will consult with Canadians on these options to develop a comprehensive set of recommendations for its final report.

The following provides a brief overview of the issues and options discussed in each chapter:

Remaining physically and mentally active are instrumental to the well-being of senior Canadians. Chapter 2 provides a series of issues and options relating to maximizing the opportunities for seniors to be active members of society through volunteer work; in educational opportunities; in opportunities for social and intergenerational interaction; and through physical activity. It explores how ageism can limit the active participation of seniors, and suggests options to eliminate ageist attitudes.

Witnesses have advocated for flexibility in retirement that would allow older workers who wish to continue working past age 65 the opportunity to do so. At the same time, the Committee recognizes that those who wish to retire should not be put in a situation that requires them to continue to work. Chapter 3 presents a range of options related to work, retirement, and income.

The Committee heard repeatedly that health is fundamental to quality of life for Canadian seniors. Canadians are not only living longer, but they are also living longer in good health. Recognizing that aging is often associated with physical and mental decline, the Committee sought options for building health, activity and fulfillment into the senior years. Chapter 4 provides options related to the services needed by older Canadians for prevention, management, and treatment of their physical and mental health.

The Committee has heard that a focus on “curing” in the health care system might detract from the “caring” aspects which help maintain a quality of life. Chapter 5 provides an overview of the issues and options related to aging in place of choice. Most seniors express a strong preference for staying in their homes as they age.

Sometimes supports are required to allow seniors to age in the place of their choice. Currently, the labour force is structured in such a way that family members and friends often have great difficulty balancing work and care for the frail elderly. Formal supports can supplement the support of family members. There are significant differences across the country in the formal supports to seniors. The chapter presents options relating to housing, supportive housing, long-term care facilities, home care, informal caregivers, and moving toward greater integration between health and social support systems in provinces and territories.

The Committee has heard that labour force mobility has exacerbated the aging of the population in some jurisdictions, particularly Atlantic Canada. Because the costs of providing health care to seniors is higher than for other age groups⁴, per-capita health funding through the Canada Health Transfer may eventually result in a widening gap in the basket of services provincial and territorial governments will be able to provide to seniors as the population ages. The Committee will seek guidance on whether this situation deserves more attention in Chapter 6.

1.7 Over-arching Observations

Population aging is the result of both a longer life expectancy and the aging of the Baby Boom generation (defined as the population group born between 1947 and 1966 inclusive). It is important to note here that, by sheer virtue of its size, the Baby Boom cohort has influenced the make-up of the total population as it has moved through the life-course. Prominent Canadian demographer David Foot notes that since the boomer generation is so numerically dominant in the Canadian population, its aging results in the aging of the Canadian population, which has major impacts on society and governments. As that cohort moves into the retirement years, there is likely to be an increased demand for services for seniors.

Several witnesses have warned the Committee, however, that the cohort following the Baby Boom cohort is considerably smaller. Some witnesses have cautioned the Committee “not to overbuild” for the Baby Boom cohort, and to recognize the temporary nature of this demographic shift. This consideration forms part of the Committee’s deliberation on issues and options.

⁴ With the exception of children under the age of 1.

The Committee notes that individuals and organizations are able to adapt to change. The changing needs which will arise out of the aging of the baby-boom generation provide an opportunity to think creatively about education, work, family and leisure throughout the life-course. For example, as we live in health for longer periods of time, it is conceivable that we will re-think the traditional school-work-retirement transitions to allow for greater flexibility at all stages of life. If this were to happen, the aging of the population will not only be a challenge to be embraced, but an opportunity to be seized.

Chapter 2: Active Aging and Ageism

The Committee believes that remaining physically and mentally active are instrumental to the well-being of senior Canadians. The Committee has heard that healthy aging and active living are promising policy approaches for dealing with an aging population. The focus of healthy aging is not only on seniors, but rather on the experiences through the life-course which result in a high quality of life in the senior years. This chapter outlines a series of issues and options proposed by witnesses before the Committee relating to maximizing the opportunities for seniors to be active members of society through volunteer work; in educational opportunities; in opportunities for social and intergenerational interaction; and through physical activity.

One of the key barriers to overcome in facilitating active aging is ageism. Ageist stereotypes and prejudices unnecessarily limit the intrinsic value to society which older people bring. This chapter also explores how ageism can limit the active participation of seniors, and identifies options to eliminate ageist attitudes.

The Committee recognizes that there may be other as yet unidentified options for promoting active aging and active living and combating ageism and welcomes discussion on those as well as the options outlined herewith.

2.1 Active Aging and Active Living

The Committee has heard that opportunities to remain physically and mentally active are instrumental to the well-being of senior Canadians. A recent report by Statistics Canada notes that many studies have highlighted the strong correlation between positive social relationships and mental and physical health and that a lack of social relationships has also been identified as a risk factor for the development of health problems.

Despite this, the evidence seems to suggest that seniors may not recognize the importance of remaining active. In fact, the Committee has heard evidence that some believe that slowing down will protect their health and allow them to live longer and healthier lives, despite research which has proven that accelerated aging is the direct result of inactivity.

The Committee has heard that if you have been physically active your whole life and involved in your community, then those aspects are likely to carry on when you retire from your work. Those who have not been involved outside their home, who have not been involved in the community, or who have not been physically active find it more challenging to begin when they retire.

Active living also requires attention to issues of urban design, transportation, and housing. This means senior-friendly cities, towns and villages that are 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 World Health Organization's *Age-Friendly Cities Guide* proposes ways to make a city more age-friendly.

An *Age-Friendly Rural and Remote Communities Guide* has been developed in Canada to produce a practical guide that rural and remote communities across Canada can use to identify common barriers and to foster dialogue and action that supports the development of age-friendly communities.

Seniors reflect the same diversity that exists among other Canadians. This results in different needs for different groups of seniors. For example, the Committee acknowledges the importance of taking into consideration the gendered roles which women have played over their life-times, and the consequences of those roles into their senior years. The role of family caregiver has an impact on financial security into the senior years, and in the availability of time to devote to activities outside the household. Culture also shapes our interests and expectations about how to spend leisure time.

Options for Facilitating Volunteerism

Volunteering has many positive benefits for both the recipients and providers of volunteer time, and volunteering is strongly associated with social connectedness. Contrary to popular belief, however, people are less likely to volunteer in their senior years than other age groups. Despite this, the average number of hours volunteered generally rises with age, from 139 hours for youth volunteers to a high of 245 hours for senior volunteers. The Committee has heard that, in addition to formal volunteerism, many senior Canadians are involved in informal support to people in their families and communities. Studies have indicated that immigrant

seniors are more likely to provide support to others without going through an organization. The Committee has heard that informal support is also important in Aboriginal communities.

The following options have been identified to facilitate volunteerism:

1- Provide tax credits for volunteerism

One way to encourage volunteerism is to provide financial recognition for their time. Tax credits for volunteer activities could facilitate volunteerism.

2- Ensure multi-year funding for volunteer activities

One of the frustrations for volunteers is the lack of continuity of funding. It has been recommended that we encourage governments to provide multi-year funding commitments so that volunteers can see continuity in the work they do.

3- Invest in infrastructure for volunteer organizations

One of the difficulties for voluntary organizations is the lack of resources to properly maintain volunteers. Financial support for a sound infrastructure for recruitment, screening, training, monitoring, evaluation and recognition within the voluntary sector might facilitate volunteerism.

4- Initiate a skills matching program

Research by Volunteer Canada has found that Baby Boomers are a more demanding group of potential volunteers who are seeking opportunities for growth and uses of their time that are new and innovative and will provide interesting and meaningful experiences. A federal program designed to match skills of potential volunteers with needs in the community might facilitate volunteerism.

5- Promote and recognize volunteerism throughout the life cycle

The Committee has heard that facilitating volunteerism in the senior years appears to be intricately linked to facilitating volunteerism throughout the life-cycle. The Committee would be interested in hearing how to promote volunteerism among all Canadians so that individuals will be poised to reap the benefits of volunteerism in their senior years. A public education program designed to promote the value of volunteering throughout the life cycle could help encourage volunteers of all ages.

Options for Educational Opportunities/ Lifelong Learning

The Committee heard that educational opportunities help seniors develop new interests and stay actively involved in the community. Life-long learning not only allow seniors to maintain a higher degree of engagement in the labour force, but can contribute to an increase in their quality of life as they feel happier, healthier, more respected and more independent. The Committee heard evidence that active learning helps maintain brain health by preventing loss of brain function and cognitive skills such as memory, reasoning and judgement.

While some seniors take courses to help them in their paid work, the Committee heard that seniors participate in continuing education activities to learn for learning's sake, to socialize and to achieve a goal. As in the case of volunteerism, 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. Thus, efforts to promote life-long learning opportunities throughout the life course benefit everyone, including seniors. Do seniors recognize the mental health benefits of continued learning? Do older Canadians want to participate in educational activities? Are they available? What are the barriers to participating? Do seniors know what is available to them?

There are a number of innovative programs across the country which promote learning among seniors; however, the Committee heard that the development of new programs could be accelerated if providers had an opportunity to meet and share ideas and best practices.

The Committee notes that continuous learning, work and participation in society forms one of the three pillars of seniors' wellness identified by Federal/Provincial/Territorial Ministers Responsible for Seniors. The following options have been identified to improve access to life-long learning:

6- Expand educational tax credits

The government currently has educational tax credits available for those who are pursuing accredited courses. Should these measures be expanded for seniors to include a broader definition of eligible courses?

7- Support a life-long learning website

Information sharing among providers of life-long learning opportunities for seniors across the country should be promoted.

A well-publicized website with links to communities throughout the country might be one way of achieving this.

8- Carry out a life-long learning awareness campaign

The mental health benefits of life-long learning could be promoted as part of a public awareness campaign.

Options for Social and Intergenerational Interaction

Social and intergenerational interaction is very important to the mental health of seniors. The Committee has heard that there are differences in social participation between different age groups of seniors. Seniors are slightly more likely to reduce their level of involvement over time.

Research on social isolation, commissioned by the Federal-Provincial-Territorial Ministers Responsible for Seniors has identified factors that contribute to the likelihood of social exclusion, including: women seniors of advanced age, seniors with less education, those dwelling in urban areas, immigrant seniors, unmarried seniors, and seniors whose health limits their activity level.

This research concluded that immigrant seniors are particularly at risk of social exclusion, even when they have been in Canada for an extended period. It is unclear whether immigrant seniors face greater levels of social exclusion, or whether they are more likely to participate in informal support networks. Given that the upcoming cohorts of seniors are likely to be even more culturally diverse than the current group of seniors, the Committee will want to explore more closely whether the social needs of immigrant seniors are being met, and if not, how they could be met.

The following options have been identified to reduce social isolation among seniors:

9- Adapt New Horizons for Seniors for Aboriginals

The federal government plays a direct funding role through the New Horizons for Seniors program, which provides grants of up to \$25,000 for community projects that 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. Should this approach be adapted for use on reserves and made available to aboriginal peoples on reserves?

10- Reduce isolation through better urban planning

Research for the F/P/T Seniors Officials working group on social exclusion found that those living in urban areas are almost three times more likely than their rural counterparts to be at risk of social exclusion. Furthermore, their research notes that 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. The federal government could facilitate opportunities for urban planners to explore the role they could play in reducing isolation in urban areas for all peoples, including seniors. The World Health Organization's *Global Age-Friendly Cities Guide* and the Public Health Agency of Canada's *Age Friendly Rural and Remote Communities Guide* could also be promoted among relevant professional groups.

Options for Physical Activity

The Committee heard that physical activity in everyday life is one of the most important strategies for maintaining physical and mental health and quality of life as one ages. It has been reported that physical inactivity represents a critical cost burden in Canada, estimated at \$5.3 million, yet the health impacts of inactivity can be offset by even small changes in lifestyle.

The Committee has heard how behaviour patterns throughout the life course affect the probability that individuals will continue to have active lives as they age. Similarly, seniors benefit from the healthy living and physical activity investments made throughout their lives. Despite this, it is never too late to reap the benefits of an active lifestyle.

While the benefits of physical activity are indisputable, many Canadians, including seniors, are not as physically active as they should be. Men are more physically active than women at all stages of life, including the senior years. 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.

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:

1. Accessibility - including transportation, time of classes, and safety to get to a facility;
2. Programming – suitability for older adults, availability of classes, lack of information on programme availability, appropriate / qualified leadership for the classes, safety within the activity (fear of injury and falling);
3. Cost - to participate in program, and transportation to get there; and
4. Psycho social support - lack of motivation, lack of social network.

The following options have been identified to promote physical activity throughout the life course and among seniors:

11- Educate Canadians about the benefits of physical activity

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 requires a greater effort to communicate this information to all Canadians, including seniors. The Committee notes that the Public Health Agency of Canada has developed useful tools, such as *Canada's Physical Activity Guide to Healthy Active Living for Older Adults*. The federal government could mount a national social marketing campaign aimed at educating Canadians about the importance of physical activity, especially for older adults. The federal government could also include pamphlets on the importance of physical activity with any mail-outs to seniors, and make these available to senior citizens' centres.

12- Eliminate barriers which limit active living

Eliminating the barriers of accessibility, programming, cost and motivation will require collaborative efforts on the parts of individuals, the private sector, non-governmental organizations, and all levels of government. Should adults be provided with tax incentives to participate in physical fitness programs, as is currently available for children? Are there accessible and affordable public transportation options to take seniors to physical fitness activities? Are there mobility differences between urban and rural areas?

13- Facilitate the sharing of knowledge and best practices

The Committee has heard that there is insufficient information sharing on active aging at the national level and there is a need for a central repository to collect and disseminate these resources so that all have an awareness of available frameworks and best practices. Furthermore, it has been suggested that the federal government play a role in the supply of trained professionals to organize exercise activities for seniors. Could community colleges and other educators be encouraged to launch programs to train physical activity instructors? How could training be provided to health care workers to help them promote physical activity participation, and to provide them a support network to which they can refer people? Could gym memberships be tax deductible?

2.2 Ageism

The Committee has heard that one of the key barriers to overcome in facilitating active aging is ageism. There are as many ways to age as there are people aging. There is no single formula outlining how to age well, or what aging will entail for any given person. Most seniors continue to be healthy and actively engaged in life. This should be held up as the norm for aging. Negative assumptions that individuals make about aging can potentially limit their active participation in life. Negative assumptions that society has about aging have also been used to limit the active participation of seniors in life. A case in point is mandatory retirement.

The Committee is of the opinion that personal independence needs to be maintained and protected for all people, including seniors. This requires a concerted effort to reframe the concept of aging, and to move away from policies which actively discriminate against seniors.

Whether assessing competency for driving or for continuing to work, chronological age has provided an expedient proxy to competency. The Committee has heard, however, that withdrawing privileges and rights based on age is a form of ageism. Ensuring that individuals are competent to work and drive is essential to maintaining public safety. At the same time, age-based practices which make it difficult for individuals to drive or practice a profession or trade on the basis of age alone is discriminatory. It will become increasingly important to come up with strategies to assess competency

throughout life, and not just in the senior years. This has already been done among some professional groups, such as physicians.

The following options for combating ageism have been identified:

14- Launch a national strategy to combat ageist stigma and discrimination

Public education campaigns to fight ageism could be developed in cooperation with community organizations. Some witnesses have suggested that curriculum on ageism and issues of aging could be integrated into training for service providers in health and social service programs across the nation. Additionally, a plan of action could be developed to raise awareness on the particular complexities associated with seniors and mental health.

15- Promote the development of alternatives to chronological age as indicators of competency

The Committee has received innovative proposals on ways to balance public safety and the rights of individuals, and would be interested in hearing more on some of these options. For example, should provincial licensing authorities create new categories of drivers' licenses which allow for limitations to driving without an outright loss of driving privileges? Should driver testing be expanded to all age groups, not only to seniors? Is there a need to communicate innovative models across the country? How could this be done?

16- Promote research on competency

Moving from age-based criteria to competency evaluation is challenging and requires sound evidence on competency. Some witnesses have suggested that we do not yet know enough about how to measure competency. What do we need to know? Others have suggested that governments, the private sector and individuals need to make more informed decisions based on what is already known about competency. How could this information be shared so that all stakeholders can make informed decisions about competency?

Chapter 3: Older Workers, Retirement and Income Security

A number of goals with respect to labour force participation and retirement income security have been identified by witnesses before the Committee: adequate incomes for seniors; an adequate supply of skilled workers for the Canadian labour market; retention of knowledge in organizations in the private, public and not-for-profit sectors; and the enhancement of choice for people as they age. The Committee is interested in both enhancing individual choice among older Canadians and identifying sustainable public policies that can support that choice and contribute to meeting the country's broader social and economic needs.

Witnesses have advocated for flexibility in retirement that would allow older workers who wish to continue working past age 65 the opportunity to do so. At the same time, the Committee recognizes that those who wish to retire should not be put in a situation that requires them to continue to work. This chapter presents a range of options identified by witnesses related to work, retirement, and income and a life-course approach to policy and programs. The Committee recognizes that there may be other as yet unidentified options concerning older workers, retirement and income security and welcomes discussion on those as well as the options outlined herewith.

3.1 Older Workers, Pension Plans, and Retirement

The Committee has heard that the average age of retirement fell gradually from a high of 65.1 in 1977 to a low of 60.9 in 1998. Since that time, however, there has been a steady increase in the labour force participation and employment rates of seniors.

The Committee investigated the factors that are most likely to influence the retirement decision. Witnesses presented Statistics Canada research data that demonstrate that defined-benefit retirement pension plans provide a strong incentive for early retirement; some of these plans allow for a maximum benefit to be achieved as early as age 55. On the other hand, the Canada Pension Plan (CPP), which provides minor disincentives for take-up in advance of age 65, has been shown to have a very minor impact on retirement decisions.

Phased retirement programs could become an effective tool for making the transition from full-time work to complete retirement more flexible. The general principle of phased retirement is simple: while income decreases along with number of hours worked, retirement benefits increase.

The 2007 Budget amended the *Income Tax Regulations* so that as of 2008 an employee can receive pension benefits from a defined benefit RPP while continuing to accumulate other benefits, subject to certain conditions.

At present, a worker is entitled to a retirement pension if he or she contributed to the Canada Pension Plan (CPP) or Québec Pension Plan (QPP) for at least one year and is at least 60 years old. Workers between 60 and 65 must have stopped working, or reached an agreement with their employer to reduce their hours in preparation for retirement with a resulting salary reduction of at least 20%. The CPP/QPP considers a person to have stopped working if his or her earned income over a 12-month period does not exceed \$11,225. Workers who are 65 or older, on the other hand, do not need to have stopped working to draw a retirement pension. This monetary ceiling could undercut efforts to promote higher activity rates among workers aged 60 to 65 who would like to remain in the labour force part-time.

Older workers with less secure employment or retirement benefits have fewer options available to them. Witnesses testified that older workers are often required or willing to work, but face dire circumstances if their employment ends involuntarily, due to injury, lay-off or inability to perform the job. Witnesses also described how the design of the Guaranteed Income Supplement (a cash benefit available to those with little other income in retirement) created a strong disincentive for recipients to earn any income from work, or even other sources. Recipients lost 50 cents in benefits for every dollar earned. The Committee was delighted with the change made in the 2008 Budget to fully exempt the first \$3,500 earned by seniors in receipt of the Guaranteed Income Supplement (GIS).

Some of the options which have been suggested to address pension-related incentives or disincentives to work include:

17- Launch an awareness campaign on the recent legislative changes that removed barriers to phased retirement

The 2007 federal budget announced measures that will encourage older workers to stay in the labour market by

permitting phased retirement, allowing an employer to simultaneously pay a partial pension to an employee while that employee is contributing to the pension plan. Is this measure likely to facilitate phased retirement? How well known is this change?

18- Restore the actuarial neutrality of Canada Pension Plan by increasing the incentive to delay uptake

Witnesses have recommended against increasing the penalty for individuals who begin to receive the CPP between the ages of 60-65. Would it be possible to increase the incentive for later uptake of CPP without adjusting the penalty for early uptake?

19- Work with the provinces to change the Canada Pension Plan so that older workers who begin to collect CPP before age 65 continue to contribute to the CPP

Currently, workers who begin to collect the CPP before age 65 stop contributing to the CPP. As a result, their employers also stop contributing to the CPP on their behalf. Witnesses have suggested that the CPP should allow older workers to continue to draw their CPP while continuing to contribute to the CPP, to continue to build up their contributions.

20- Work with the provinces to change the Canada Pension Plan so that individuals between the ages of 60 and 65 who want to apply for CPP and continue working no longer have to quit work or earn up to the maximum of CPP in the months prior to the application

The Committee has heard that the current practice discourages continued work.

21- Undertake both an awareness campaign against discrimination against older workers and more aggressive scrutiny of the treatment of older workers for compliance with existing legislation and regulations

Create effective incentives to encourage training for willing older workers.

22- Amend the Employment Insurance program to provide benefits to unemployed older workers, rather than forcing early reliance on CPP or other pensions that may penalize for early withdrawal

Witnesses have described situations in which older workers who become unemployed draw their CPP benefits early when they become unemployed, thereby reducing the amount of the

benefit. Could changes to EI provide a mechanism that would prevent this loss of benefits?

3.2 Adequacy of Retirement Incomes

Witnesses demonstrated that wealth is rising among younger Canadians as they age, but is based almost exclusively on the increased value of their homes. Although this wealth could be turned into income on the sale of their homes, this would run counter to the principle of encouraging “aging in place”. Therefore, seniors may be asset-rich, but income-poor.

Other witnesses pointed out that seniors who do not own their own homes are more vulnerable to poverty, because increasing rents take a larger bite out of a relatively fixed income. Options to address this vulnerability, including the funding of additional affordable housing, have been elaborated in Chapter 5.

Options for consideration include the following:

23- Explore options for other forms of income streams

Witnesses described the need for income from their assets, but existing “reverse mortgage” mechanisms can result in unfair practices affecting the homeowners and their equity. Are there other alternatives which could be considered?

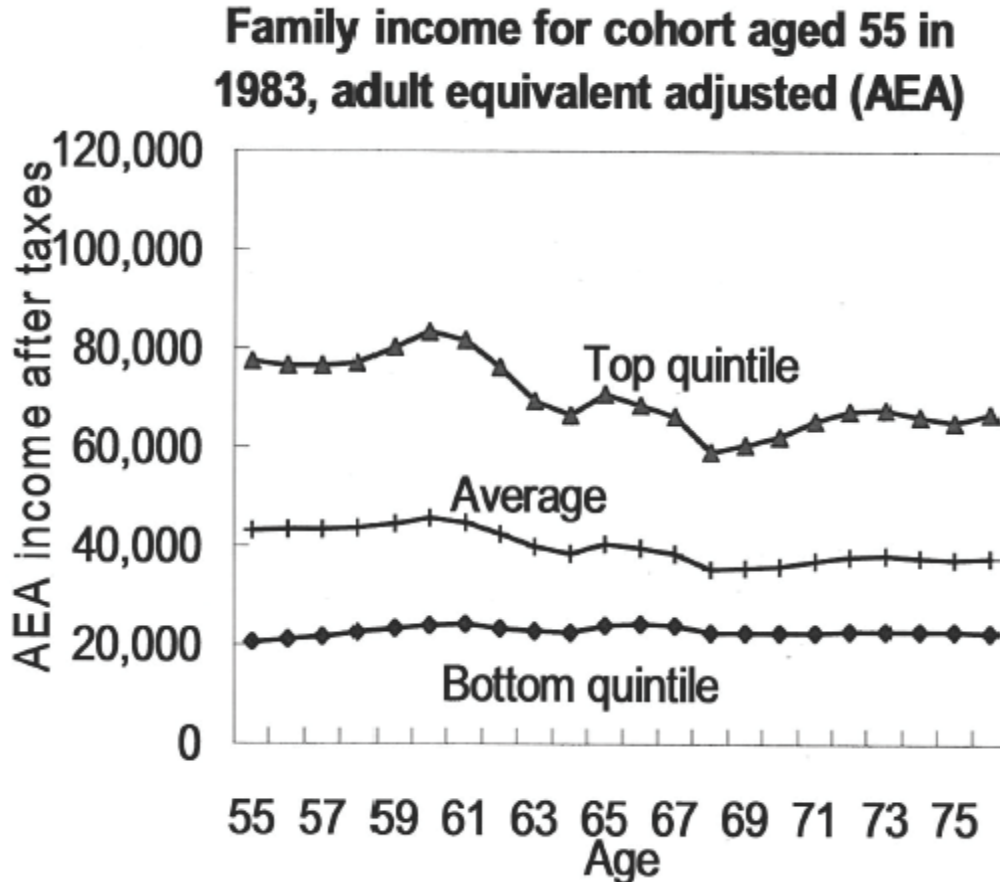
Options for Addressing Poverty

In its interim report, the Committee posed a question for further exploration: What can be done to improve the low-income rate and other risk factors for unattached seniors?

Statistics Canada officials appearing before the Committee described income for seniors in terms of replacement income levels of older Canadians; this measure compares incomes at age 65 among retirees with their incomes at age 55. The research shows that people in the lowest income groups have replacement level that is equal to or higher than their income before retirement. Middle-income retirees have replacement levels that are almost as high. Only individuals who were in the highest income group at age 55 may see a lower replacement rate at age 65. However, even with a lower replacement level, they continue to enjoy higher incomes at age 65 than groups who had lower incomes at age 55. (See Figure 3.1 below.) The researchers also point out that income

replacement levels for middle and higher income groups over the age of 85 decline, probably due to depletion of private savings.

Figure 3.1



Source: Morissette, René, Garnett Picot and John Myles. *The Wealth and Income Position of the Retirement and Pre-retirement Populations*. Presentation to the Special Senate Committee on Aging, February 11, 2008.

Sources of income vary for seniors, and may include earnings from work, private pension benefits, CPP benefits, RRSP withdrawals, other investments, Old Age Security (OAS) and the Guaranteed Income Supplement (GIS).

Private pension plans are correlated to years of service and income earned from employment with a specific employer. CPP benefits are funded by contributions by employers and employees, and therefore are diminished by any withdrawals from the labour market. While special provisions have been made for those who drop out to care for their young children, there is no similar provision for care of other family members. CPP has a relatively

low threshold (the average wage), above which contributions are not collected from employers or employees, and is intended to replace only 25 percent of employment earnings up to that threshold.

Many seniors have incomes below Statistics Canada's low-income cut-off lines (used as a poverty line in this report), but their poverty is not deep. That is, their incomes are usually 90 percent or more of the low-income cut-off level. Many rely on OAS and GIS as their only sources of income. If they live in smaller communities, income from OAS/GIS may exceed the low-income cut-off (LICO) line. Seniors who are below the line are often living alone and/or in large cities.

Further, the committee heard that not all eligible seniors are receiving all the benefits to which they are entitled, either because they are unaware of the application requirements or of their eligibility. This includes eligibility for retirement benefits under the Canada Pension Plan. When eligible recipients do apply later than the age at which they became eligible, retroactive benefits can be paid for up to 11 months.

Options for addressing poverty include the following:

24- Make OAS/GIS benefits non-taxable if they are the only source of income

Some low-income seniors pay income tax. The current basic exemption from income taxation is lower than the maximum individual benefit of OAS and GIS combined. Could there be a different basic deduction for seniors that would be equal to the combined OAS and GIS payments? Could the same goal be accomplished through a carefully designed tax credit for seniors?

25- Propose to provincial governments that survivor's benefits under CPP be sustained at the same level after the death of the spouse

What actuarial impact would this have on CPP? Are there other mechanisms to ensure that survivors, predominantly women, do not face sudden drops in their income upon the death of a spouse?

26- Modify GIS to keep seniors from dropping below low-income cut-off lines

Given that LICOs vary not only by household size, but by the population of the community of residence, is there a way to vary

the GIS by size of community? Could it be managed with a special supplement for residents of large communities?

- 27- Work with provincial governments to increase the income replacement rate for the CPP (currently 25% of income up to the average wage) and/or to increase the maximum pensionable earnings beyond the average wage**

Could the maximum income on which contributions are collected be increased from \$40,500 to \$60,000, as recommended by some witnesses? What impact would increasing the CPP replacement level from 25% to 50% (over time) have on retirement incomes, employment trends, and labour force participation?

- 28- Analyze any changes with respect to retirement income to assess and correct for differing impacts on men and women**

Federal government policy requires gender analysis of new policies. Is this policy in place for retirement income policies, programs and regulations?

- 29- Undertake more aggressive campaigns to ensure that all eligible Canadians are receiving all retirement- and age-related benefits**

Quebec has virtually no gap between those eligible and those receiving Quebec Pension Plan benefits. How could the federal government emulate the practices in Quebec that achieve this outcome, including a longer period of retroactivity? Are there other approaches that would have the same result?

- 30- Make retroactive repayments with interest to eligible recipients who did not apply for OAS at 65 or CPP at 70, or who were denied benefits due to administrative errors and make these payments cover the period between the ages specified and the age at which repayment is made**

This option is intended to increase the fairness of the administration of these benefits and to provide an incentive to the government to ensure that all eligible beneficiaries receive their benefits. Would such a change accomplish these goals? Are there impacts from such a change that would have a detrimental effect on either the economic security of individuals or on the income programs themselves?

3.3 Services and Income

While income is an important factor in well-being among seniors, services provided by government or non-government organizations are often of equal or greater importance. Examples are subsidized or free prescription drugs or home care provided without charge.

In some provinces, such services are free only if the senior is in receipt of the Guaranteed Income Supplement (GIS). This discourages seniors from earning income which might result in their no longer being eligible to receive GIS. Combined with the "claw-back" to the GIS of 50 cents on every dollar of earned income, this has created an effective tax of more than 100 percent; that is, the combination of earned income and the loss of subsidized services could leave someone with less income and services than before they earned any income. Effectively, then, GIS recipients may be unable to improve their circumstances, including through paid employment.

Options to address this could include:

- 31- Harmonize the design and operations of Old Age Security and the Guaranteed Income Supplement and supports and services (largely provincial) so that modest increases in income do not result in a reduction of supports or services**

Could the federal government partner with one or more provinces to pilot such a harmonization experiment?

- 32- Develop a federal/provincial/territorial accord to ensure that increases in OAS and/or GIS do not result in loss of eligibility for subsidies or services for seniors**

Are there any precedents for such an accord? Are there any existing mechanisms or decision-making bodies that could facilitate such an accord?

3.4 Life-course Approach to Policy and Programs

The Committee has heard broad-ranging testimony on the increasing labour-force participation of women, the increase in hours worked in recent years, and increasing pressures to provide informal care-giving. Taken together, these reflect significant changes in how Canadians allocate their time over the life-course to work, care-giving,

education and leisure. Yet social policy and programs have changed in a piece-meal fashion that is not coherent, creates gaps, and reduces the ability for Canadians to respond the way they would wish to varying demands.

The Committee has also heard that analysis has begun of these policies and programs, and of how Canadians do allocate time and resources over the life-course; this analysis could inform a more comprehensive consideration of social policies and programs to be more responsive to the shifting realities facing Canadians today.

Consideration of this approach suggests the following option:

33- Reconsider the design of CPP in light of increasing variations in labour force participation

CPP already has drop-out provisions for parents of children under the age of 7. In addition, there is a general drop-out provision. Recommendations elsewhere in this report suggest the development of drop-out provisions for care-giving. As it continues its study, the Committee will explore whether programs such as CPP continue to be responsive to the increasing variability in labour force participation over time. Could a life-course analysis and approach result in greater flexibility and security over a lifetime, including at the time of retirement?

Chapter 4: Healthy Aging

The Committee heard repeatedly that health is fundamental to quality of life for Canadian seniors. The health of seniors is determined by many variables. Witnesses reiterated the importance of the determinants of health and the population health approach identified by the Public Health Agency of Canada in enhancing the quality of life for seniors. Health determinants, such as income and social status, social support networks, education and literacy, and employment/working conditions, have cumulative effects on health and well-being in later life. When the determinants of health are positive throughout life, seniors spend more years as 'young old' and 'middle old,' and fewer years in the 'frail old' stage of life.

Canadians are not only living longer, but they are also living longer in good health. Indeed, some may remain in good health all their lives. Recognizing that aging is often associated with physical and mental decline, the Committee sought options for building health, activity and fulfillment into the senior years.

This chapter provides options identified by witnesses related to the services needed by older Canadians for prevention, management, and treatment of their physical and mental health. It includes discussions on health promotion and disease prevention, the care versus cure debate, the need for specialists in gerontology and geriatrics, chronic disease, palliative care, mental health and the health needs of groups under federal jurisdiction.

The Committee recognizes that there may be other as yet unidentified options for promoting healthy aging and welcomes discussion on those as well as the options outlined herewith.

4.1 Health Promotion and Disease Prevention

Health promotion and disease prevention strategies can keep people healthier and improve their quality of life. By reducing the rates and impacts of certain conditions, they can also help contain healthcare costs. Health promotion initiatives, such as nutrition and physical activity programs, reduce many risks associated with aging. But for prevention strategies to be most effective, they must be directed at people of all ages, and not just seniors.

One important issue for health promotion for seniors is falls and injury prevention. Injuries from falls can have a disastrous effect on the health and autonomy of seniors. The Committee heard that among seniors, falls are responsible for 84 percent of injury-related hospital admissions and 40 percent of admissions to nursing homes or long-term care facilities.

Physical weakness and hazards in the environment are the principal risk factors for falls. It has been suggested that reversing strength loss in many older people could have a significant impact on the health of the country. Options for promoting physical activity among seniors are discussed more fully in Chapter 2. Witnesses have also raised the problem of poor footwear, stressing the importance of choosing proper shoes to prevent falls.

Falls can also be associated with the use of certain medications. The chronic conditions associated with aging require a variety of medications, each with potential side effects and possible negative interactions. Studies have revealed that between 18 and 50 percent of drugs taken by seniors are not used appropriately. It is not surprising, then, that between 19 and 28 percent of hospitalizations of patients over the age of 50 are attributable to medication problems.

The cost of medications is also a concern for seniors living on fixed incomes. The Committee has heard that prescription drug insurance coverage varies significantly from province to province, leaving many seniors vulnerable to financial hardship. For example, medications approved by Health Canada to treat Alzheimer's disease may not be listed on all provincial formularies, preventing access to seniors who cannot afford the high cost of purchasing the medication.

The following option for affordable medications has been identified by witnesses:

34- Establish a national comprehensive publicly-insured or publicly-privately-insured prescription plan

Recognizing that the cost of prescription drugs has risen dramatically in recent years, a national plan would ensure equitable access to medically necessary medications across the country, regardless of ability to pay.

Options for Improved Nutrition

The role of food in promoting good health and in preventing ill health is well documented. Seniors can prevent or control the higher

rates of heart disease, cancer, high cholesterol and high blood pressure associated with aging through healthy eating and regular physical activity.

Witnesses noted that healthy nutrition needs to be encouraged from an early age. The entry point for preventing obesity among future generations of seniors lies with changes to the eating habits of today's children and youth.

Barriers that can prevent seniors from maintaining a healthy diet include lack of dental care and the cost of food. Because dental care and dentures may not be publicly funded through the health care system, some seniors cannot eat properly. Low income households in northern communities also have problems accessing affordable food.

The following options for improving nutrition have been identified:

35- Introduce public information campaigns about nutrition, targeted at seniors and the general population

A better understanding the negative effects of poor nutrition can reinforce campaigns aimed at current and future seniors.

36- Ensure that the dental care programs for First Nations and Inuit, veterans, and inmates in federal facilities cover the costs of dentures

Ensuring that seniors for whom the federal government has direct responsibility have access to dentures when needed is a first step to promoting proper nutrition.

Options to Combat Abuse and Neglect

Senior abuse includes financial, physical, sexual, and emotional neglect, abuse, and violation of rights and can be perpetrated in the home or in institutions. The Committee heard that 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.

Witnesses talked about the many factors that contribute to the abuse of older Canadians, including caregiver burn-out, inadequate training of healthcare workers, and understaffed facilities. Although the care needs in long-term care facilities are increasingly complex, staff have not been sufficiently trained in complex care. This environment can contribute to staff burnout, decreased quality of care,

neglect and abuse. Caregiver supports are discussed more thoroughly in Chapter 5.

Witnesses have suggested that changes to the *Criminal Code* to create specialized offences for elder abuse are not necessary – proper enforcement under existing laws would be sufficient. Ontario's Bill 140 has been cited as a widely-acclaimed model for the way it sets standards and proposes a protocol in instances of abuse in the care of seniors.

The following options to address abuse and neglect have been identified:

37- Develop supports for caregivers and promote education to prevent burnout

Respite care services and support programs that help caregivers deal with the challenges they face can contribute to preserving the health and well-being of the caregiver, improving the care offered, and delay institutional placement or instances of abuse.

38- Improve training for the continuum of human resource workers on seniors' needs

A better understanding of seniors' needs can assist care providers in adapting services and responding more effectively to seniors' unique realities.

39- Share best practices on the prevention of elder abuse

A great deal of progress has been made in various jurisdictions' efforts to prevent elder abuse. Investments in transferring that knowledge would help other regions scale up their elder abuse prevention strategies.

40- Sign the Hague Convention on the International Protection of Adults

As a signatory to the Hague Convention, Canada would have mechanisms for settling international disputes that can arise when the care and competency of seniors crosses national boundaries.

4.2 Social Care

Healthy aging is not just about an absence of illness but is strongly related to the strength of social networks supporting Canada's seniors. The medical model is still dominant, however, when thinking

about seniors' health. Witnesses drew a distinction between "curing" associated with the medical model and the "caring" needs of people in the community and the home. The level of social care provided through community and family is important to health status.

Older Canadians face a complex web of social and health services from multiple levels of government, with mandates that overlap those of community and private sector organizations. A comprehensive approach integrating health and social services for older adults has been shown to be cost-effective and to reduce rates of institutionalization. Options for moving toward a more integrated system of care are discussed in Chapter 5.

4.3 Gerontological and Geriatric Specialization

There is a shortage across the country of individuals trained through gerontology and geriatrics. This is compounded by the small numbers of medical students entering the field, and the aging of the healthcare workforce.

The incorporation of interdisciplinary education about aging into the core programs of all health professionals would improve the delivery of age-appropriate services. Expanded professional training in geriatric medicine, gerontological social work and gerontological nursing would help address the health human resource needs of the aging population. Witnesses have also suggested that finding a way to recognize the credentials of immigrants with health care training, and to raise the level of necessary credentials in a timely fashion, could also help alleviate the shortage of health care professionals.

The following option has been identified to address the need for more individuals training in geriatrics and gerontology:

41- Support capacity building projects for training in geriatrics and gerontology

Increasing the number of geriatric and gerontological training programs, or expanding the number of students existing programs are able to reach, would help strengthen gerontological and geriatric education in Canada.

4.4 Chronic Diseases

Chronic disease is a major concern for seniors. The Committee has heard that the most common chronic conditions affecting seniors are heart disease, arthritis, diabetes and dementia. Although 70 percent of seniors who suffer from one chronic disease also suffer from other additional chronic conditions, the management of co-morbidities has not been well studied. Chronic disease affects people's physical, emotional and mental well-being and often makes it difficult for them to carry out daily tasks.

The healthy aging framework and attention to the social determinants of health can provide ways to prevent the development of chronic disease. This is particularly important for Aboriginal peoples, who are especially affected by chronic diseases. First Nations seniors report suffering from concurrent, long-term health conditions such as arthritis, rheumatism, high blood pressure, asthma, heart disease, and type 2 diabetes.

4.5 Hospice Palliative and End-of-Life Care

Hospice palliative and end-of-life care is often said to not be about dying but about living well until the end. Through pain and symptom management, as well as physical, emotional, psychosocial, and spiritual care, those at end of life, and their families, are supported. It is an issue especially important to seniors and their families. More than 259,000 Canadians will die each year, and approximately 75% of these deaths will be people 65 years and over. Statistics Canada has projected that the rate of death in Canada will increase by the year 2020 to more than 330,000 deaths, an increase of 33 percent over 2004. Witnesses have estimated that each death potentially impacts the health and well-being of an additional five people.

There are many disparities in the delivery of palliative care across Canada, and it is estimated that only 25% of Canadians requiring hospice palliative and end-of-life care services are able to access these services. Considerable evidence exists that older people suffer unnecessarily due to widespread under-assessment and under-treatment of their problems as well as lack of access to hospice palliative care.

The following options have been identified for improving access and availability of quality end-of-life and palliative care:

42- Implement a funded national partnership on palliative care

Such a partnership would provide leadership and vision and promote standards and best practices necessary to ensure the provision of quality end-of-life care for all Canadians.

43- Implement a public education program to inform Canadians about end-of-life services and the need for advance care planning

44- Increase training and education opportunities surrounding palliative and end-of-life care for health professionals and volunteers

45- Apply the gold standards in palliative home care to veterans, First Nations and Inuit, and federal inmates

The Canadian Hospice Palliative Care Association and the Canadian Home Care Association have issued gold standards in palliative home care. The federal government could assess whether they are meeting the standards for veterans, First Nations and Inuit, and federal inmates. They could then develop an implementation plan to address shortcomings.

4.6 Mental Health, Mental Illness and Dementia

In addition to physical illnesses, seniors experience mental illnesses including mood, anxiety and psychotic disorders as well as emotional, behavioural and cognitive complications and a variety of brain diseases such as Alzheimer's disease, stroke and Parkinson's disease. Witnesses reminded the Committee that while some individuals experience the onset of mental illnesses as a senior, others have lived with mental illnesses much of their lives. Nonetheless, mental health problems in later life are significant and frequently complicated by disability and poor social support. Studies suggest that between 15% and 25% of nursing home residents have symptoms of major depression, and another 25% have depressive symptoms of lesser severity. The Committee heard that problems such as depression are too often viewed as an inevitable part of aging.

Witnesses called for specific interventions designed to delay the onset of mental illness or dementia; for supports to mitigate the impacts of the disease on patients and their families; and for early diagnosis. Options for supports to individuals and their families are addressed in Chapter 5.

The following option has been identified:

46- Develop tools to facilitate the early diagnosis of mental health conditions

Timely diagnosis could allow for the use of effective therapies to slow the progress of Alzheimer's disease, reduce excess disability caused by depression and anxiety, and allow for patients with treatable conditions to regain their quality of life and prevent or delay long-term care placement.

4.7 Groups under Federal Jurisdiction

While any focus on healthy aging falls across a range of jurisdictions, the federal government has more room for action when meeting its responsibility to ensure that health care services are provided directly or indirectly to several specific population groups, including veterans, on-reserve First Nations and Inuit, and federal offenders.

Veterans

Veterans Affairs Canada currently provides veterans who meet certain criteria with medical, surgical, dental, psycho-geriatric, palliative and respite care along with other community health care services and benefits on the basis of need. The department's Gerontological Advisory Council has recently promoted a comprehensive, integrated approach that would lead to improved health, quality of life, and satisfaction for older adults. It also reduces both the burden on family caregivers and health care costs. The social care components of services to veterans are discussed in Chapter 5.

First Nations and Inuit

Health Canada currently offers health services – considered to be medically necessary but not covered by private or provincial/territorial health plans – through the Non-Insured Health Benefits (NIHB) Program. Health Canada also provides a range of community-based programs for seniors while Indian and Northern Affairs Canada supports social programs.

Witnesses told the Committee that NIHB costs have increased about 14 percent every year but because of cost containment, the program is capped at 3 percent. The cost containment is seen as detrimental to the development of long-term care measures and has

led to the elimination of foot care and other supportive services directly affecting elders and potentially leading to increased levels of disability. As well, some health and social providers are asking for cash before giving services, creating a significant barrier for low income individuals.

The following options have been identified:

- 47- Remove the 3 percent cap on NIHB health services**
Alternative cost containment mechanisms can be sought which impose a less arbitrary measure of health service needs.
- 48- Expand eligible expenses under the Non-Insured Health Benefits Program to include the cost of foot care**
In a time of growing diabetes rates, not providing foot care will only create more significant – and costly – complications for First Nations seniors.

Federal Inmates

The Correctional Service of Canada (CSC) is responsible for the care and custody of offenders serving sentences of two years or more. Senior inmates form a small but growing proportion of these inmates. CSC defines senior inmates as inmates aged 50 and over, because research has demonstrated that the aging process is accelerated by 10 to 11.5 years for offenders due to the cumulative effect of factors such as socioeconomic status, lifestyle and access to health care.

CSC has a legal obligation to provide inmates with essential health care. However, the Committee heard that some offenders miss medical appointments because it is not possible to find an escort to accompany them. It also heard that access to patient-centred chronic, long-term and palliative care in federal corrections is very limited, and additional resources are required. Further options relevant to the health of federal offenders are outlined in Chapter 5.

The following option to address these issues has been identified:

- 49- Ensure that senior inmates in correctional facilities receive necessary support aids in a timely fashion**
The Office of the Correctional Investigator has investigated cases involving significant delays in obtaining items critical to an offender's well-being and dignity, such as hearing aids, dentures and adult incontinence products.

Chapter 5: Aging in Place of Choice

Canadians should be able to grow older in the place of their choice. Most seniors express a strong preference for staying in their homes as they age. Sometimes supports are required to allow seniors to age in the place of their choice. Currently, the labour force is structured in such a way that family members and friends often have great difficulty balancing work and care for the frail elderly. Although formal supports can supplement the support of family members, there are significant differences across the country in the formal supports to seniors.

This chapter outlines a series of issues and options proposed by witnesses before the Committee related to aging in place of choice. It presents options relating to housing, home support and home care, transitioning to integrated care, and needs of groups under federal jurisdiction.

The Committee recognizes that there may be other as yet unidentified options for supporting aging in place of choice and welcomes discussion on those as well as the options outlined herewith.

5.1 Housing

Most seniors (93%) live in private homes, and have a strong preference for staying in their own homes. Factors which push seniors to move out of their homes include inappropriate design or size of the home, loss of a spouse or decline in health. Some may no longer be able to afford their homes or keep up with home maintenance.

The Committee has heard it is more efficient to plan and build housing and neighbourhoods that will continue to meet the needs of people as their health status changes. While building regulation is the responsibility of provincial and territorial governments, most provinces and territories adopt or adapt the model *National Building Code* and enforce its requirements.

CMHC has two programs, the Residential Rehabilitation Assistance Program and the Home Adaptations for Seniors' Independence (HASI) program, to make sure that homes can be adapted to allow low-income seniors to live independently in homes that meets basic health and safety standards.

Furthermore, the Committee has heard that the lack of affordable housing poses particular challenges for single seniors, seniors in urban areas and Inuit seniors. Aboriginal organizations have stressed that the lack of quality, affordable housing is one of the greatest challenges to Inuit, Métis, and First Nations seniors.

The following options have been identified to address housing design, affordability and adaptability:

50- Increase publicity about CMHC home adaptation programs

The Committee has heard that some Canadians who are in need of funding for renovations may not know that these programs exist.

51- Increase the stock of affordable housing across the country

52- Increase the availability of vouchers to allow low-income seniors to pay for adequate housing

53- Ensure that the standards for barrier-free design that are already contained in the *National Building Code of Canada* are consistently met by builders or enforced by inspectors

Options for Assisted Living and Supportive Housing

For seniors who need more assistance, supportive housing can provide support services such as meals, housekeeping and social and recreational activities. The Committee has heard that the costs of supportive housing, difficulties accessing information on available choices, and the lack of regulation are issues which need to be addressed.

The cost of supportive housing is a barrier for some seniors. Seniors who own their homes may feel that they can control their costs at home better than in supportive housing. The Committee has heard that it is very difficult to access information on supportive housing options in other jurisdictions, posing a challenge for seniors who may want to move.

Supportive housing and assisted living are not heavily regulated across the country. Witnesses have noted that some assisted living facilities are providing levels of care that go beyond basic supports,

cautioning against assisted living facilities becoming entrenched as unregulated long-term care facilities. There is an assumption that supportive housing needs minimal regulation because consumers can exercise choice, thus placing upward pressure on service standards. This requires choice for consumers – a choice which does not exist in many parts of the country.

The following options have been identified concerning supportive housing:

54- Increase the stock of affordable supportive housing

Would initiatives to increase the supply of affordable supportive housing put upward pressure on all providers of supportive housing to ensure that minimal standards are met? Should the Canada Mortgage and Housing Corporation play a greater role in stimulating the development of supportive housing across the country?

55- Increase the supply of affordable supportive housing for First Nations and Inuit seniors

56- Improve the regulation of supportive housing across the country

Should the federal government play a role in the communication of best practices in regulation? Do different jurisdictions get together to so that they each do not need to “re-invent the wheel” in developing a regulatory framework for supportive housing?

57- Facilitate access to information about housing options across the country

Should a central information database be developed to share information on supportive housing options which exist throughout the country? If so, what would be the best way to get this information to seniors?

Options for Long-term Care

Although most seniors will not live in long-term care facilities, it is a necessary housing option in some instances. There is variation across the country in the level and type of care offered in long-term care facilities, co-payment arrangements, and how institutions are governed. The majority of these facilities (outside of Quebec) are privately owned, with the rest evenly distributed among non-profit

organizations and governments. The direct service role of the federal government for long-term care is elaborated in Section 5.4.

There is no portability for long-term care services between jurisdictions. Witnesses have suggested that Canadians may not be aware that services such as long-term care are not provided in the publicly funded health care system.

The portability criteria under the *Canada Health Act* ensures that residents moving from one province or territory to another continue to be covered for insured health services by the "home" jurisdiction during any waiting period imposed by the new province or territory of residence. This portability criteria does not apply to the extended health care services under the *Act*, including long-term care.

The following options have been identified:

58- Encourage the provinces and territories to make reciprocal arrangements to eliminate the waiting period for residents from another province

As they move across the country, seniors may have to pay the full fee of the long-term care facility for a waiting period before being eligible for cost-sharing through their new province or territory of residence. This is an insurmountable barrier for some seniors and their families.

59- Communicate information and best practices about adapting long-term-care facilities to address the needs of a multi-cultural society

Providing culturally sensitive services that meet the needs of immigrant seniors will become increasingly important to ensure that they find facilities that meet their needs.

5.2 Home Support and Home Care

Home care programs include 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. Much of the home care and home support required by seniors is provided informally within the family. This raises the issue of how we support informal caregivers.

Studies on the cost-effectiveness of home care have demonstrated that home care services generally cost governments less than residential care services for people with the same levels of care need. These studies have also found that the majority of the home care services required is for non-professional home support services. Approximately 32,000 individuals provide home support across Canada at this time, and that this number is likely to double in the next decade. Although these workers are part of the continuum of the workforce serving seniors, there are significant variations in qualifications and training requirements across the country.

The *Canada Health Act* makes reference to home care under its definition of extended health care services. Since the 2004 First Ministers' Accord on Health Care Renewal, however, short-term home care has been recognized as a part of the acute care system. Some have suggested that this focus on acute care home care has had the unintended negative consequence of reducing the availability of longer-term care.

The following options have been identified to improve access to home care:

60- Introduce a National Home Care Program

The patchwork quilt of home care services has resulted in a call for a national home care program with standards and with the provision of core services comparable from province to province. Would there be a danger that a national home care program would result in a reduction of services in jurisdictions which already have exceeded the scope of a standardized program? Given that different jurisdictions have different resources, is there a danger that a standardized program would put excess pressures on those jurisdictions which have less?

61- Address the uneven qualifications and conditions of work of home care staff

The Committee heard that non-professional or paraprofessional workers provide most of the paid home care services in the country. It has been suggested that the lack of a national human resource strategy and training standards for this sector has a significant impact on the quality of care from one region to another. Is there a role for the federal government in planning a human resource strategy aimed at home care workers? Could the federal government fund the creation of a national training curriculum for home care workers?

62- Create a registered chronic care savings plan

Because home care is not entirely publicly funded, some witnesses have suggested that Canadians be urged to save so that they will eventually be able to afford the services to meet their needs. This could be done through the creation of a registered chronic care savings plan, similar to an RRSP.

Options for Supporting Informal Caregivers

The aging population is translating into an increased need for individuals to care for family members or friends. Informal caregivers provide about 80% of all home care to seniors living in the community. The majority of family caregivers provide care because they see it as a family responsibility or they simply choose to do so. A significant number indicate they have taken on this role because there is no one else available or because there is a lack of home care services.

Being a caregiver presents physical, mental, emotional, and financial challenges to caregivers, particularly for those who balance caregiving and paid employment.

The following options for providing support to informal caregivers have been proposed to the Committee:

63- Provide information to caregivers

Caregivers need information and education to care for themselves as well as those they are supporting. In Canada, there is no one-stop shopping for caregivers.

64- Create a National Respite Program

Currently, the availability of caregiver support depends on where individuals live, how much money they have and for whom they are caring. The creation of a national respite program would help caregivers get the physical and emotional rest they need to provide care.

65- Make Changes to the Compassionate Care Benefit

Compassionate care benefits under the Employment Insurance program are paid to persons who have to be away from work temporarily to provide care or support to a family member who is gravely ill. Some eligible Canadians do not know about the program. A number of improvements have been suggested to make the EI Compassionate Care Benefit more flexible, more widely available, and available over a longer period of time. This

could include delivering the benefits outside the Employment Insurance program in order to extend eligibility for the Compassionate Care benefits to groups who cannot access Employment Insurance. Changes to the EI benefit might include: a broad public information campaign about the availability of the benefit; increases to the length of the benefit; and broader definitions for eligibility under the program.

66- Provide financial support to caregivers

A number of proposals have been put forth to reimburse caregivers for expenses or to provide financial recognition of their work. The federal government could offer enhanced financial assistance to home care consumers through allowances, tax deductions and reimbursable tax credits to offset the costs of caregiving at home. It has been suggested that the federal government could convene an expert panel on the financial security of caregivers.

67- Introduce a Canada Pension Plan (CPP) drop-out provision for caregivers

Taking time off to care for ailing family members can result in reduced entitlements under the CPP. The CPP currently allows people who have left the workforce temporarily to care for their children to drop these periods of little or no income from the calculation of CPP benefits. These CPP drop-out provisions could be extended to support informal caregivers who have left the workforce to care for ailing relatives.

5.3 Support for the Transition to Integrated Care

Allowing seniors to age in the place of their choice requires a myriad of services, including adequate and affordable housing options, long-term care, community support services and home care. Ensuring that the right care is delivered at the right time in the right setting requires a high level of integration and coordination of services. The Committee has heard compelling evidence that the most pressing need is the integration of the various support options available to seniors.

The integration of these services could alleviate the pressure seniors and their families currently face as they try to navigate the multitude of available services to meet ever-changing needs. Integration and coordination creates greater efficiencies and allows governments to get better value for money. A move toward integrated

care is happening in some jurisdictions across Canada, but there has been a lack of national leadership in this area.

The following options have been identified to address the need for integrated care:

68- Introduce a National Policy Initiative for Integrated Care

The federal government could help provincial governments address the costs of an aging population by helping them move toward models of integrated care. Witnesses have suggested that the federal government work with the provinces, through the Social Union Framework Agreement, to develop a federal funding initiative which would provide financial support to the provinces to facilitate the move toward integrated models of care for the elderly. The goals and conditions of the program could be designed to ensure:

- A move toward one-stop-shopping for seniors and their families;
- Improved portability of services between provinces; and
- A greater emphasis on independent living.

69- Share of best practices related to integrated care

Integrated care is happening across the country with minimal opportunities to share experiences across jurisdictions. This is even the case between government departments with Veterans Affairs offering one of the leading models of integrated care in the country in contrast to the care provided by the Government of Canada for First Nations people. How could the federal government facilitate information sharing in this area?

5.4 Groups under Federal Jurisdiction

The federal government delivers direct services to eligible veterans, First Nations on-reserve and Inuit in designated communities and federal inmates.

Veterans

The Veterans Independence Program (VIP) is a national home care program provided by Veterans Affairs Canada to help eligible veterans remain in their own homes or communities. Through this program, war service veterans who served during the First and Second

World Wars and the Korean War may be eligible for a range of services, including grounds maintenance, housekeeping, personal care services, access to nutrition services, and health and support services.

The following options have been proposed by veterans' organizations:

70- Create a needs-based 'Seniors Independence Program' for all Canadian seniors, modelled after the Veterans Independence Program (VIP)

71- Expand the Veterans Independence Program to all Canadian Forces veterans

Many Canadian Forces veterans, including peacekeepers, are not eligible for the Veterans Independence Program.

First Nations and Inuit

If services to veterans represent a model of supports to seniors, the same cannot be said of the services to First Nations and Inuit seniors. The housing needs in First Nations and Inuit communities are great. Representatives of First Nations, Inuit and Métis peoples have made it clear that the primary need of seniors is access to adequate and affordable housing.

Although Health Canada's First Nations and Inuit Home and Community Care Program serves seniors, persons with disabilities and persons suffering from chronic illness, and Indian and Northern Affairs Canada (INAC) operates an Assisted Living Program that provides non-medical social support services to First Nations people, there are significant support needs among First Nations and Inuit people. The Committee has heard that a 20-year long moratorium has been in place in terms of the construction and operation of personal care homes. The Committee has also heard that inadequate medical and support services on reserves can exclude Aboriginal seniors from the benefits of living and/or dying at home with their family.

Indian and Northern Affairs Canada and Health Canada are co-funding a multi-stakeholder initiative for developing a national policy program and program framework for continuing care, of which assisted living is an integral part.

The following options have been proposed to the Committee:

- 72- Increase the stock of adequate and affordable housing for First Nations and Inuit**
- 73- Provide First Nations and Inuit with the same package of services available to war service veterans in the VIP program**

Federal Inmates

The Correctional Service of Canada (CSC) is responsible for the care and custody of offenders serving sentences of two years or more. The needs of senior offenders are different from those of younger offenders. Although research indicates that programs designed specifically for senior offenders have positive outcomes, such support may not be currently available in federal institutions.

Options which have been proposed to the Committee include:

- 74- Implement the recommendations contained in the Correctional Service of Canada's (CSC) *Report on Elderly Offenders***

In 2000, the CSC developed a strategy that would make it possible to better meet the specific needs of older offenders. The Committee has heard that implementation of this strategy has been stalled.

- 75- Amend the Corrections and Conditional Release Act by adding offenders who are elderly or who have serious health problems to the list of offender groups with special needs**

The Elizabeth Fry Society suggested that conditional release arrangements could provide opportunities for individuals to go into senior homes, other age-appropriate residences or palliative care facilities instead of trying to develop those within prisons themselves.

- 76- Amend the Corrections and Conditional Release Act to make terminally ill offenders serving life sentences or indeterminate sentences eligible for parole on compassionate grounds**

The Committee has heard that Section 121 of the *Corrections and Conditional Release Act* allows parole by exception to be granted 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, or for whom continued confinement would constitute an excessive hardship that was not reasonably foreseeable at the time the offender was sentenced. These exceptions do not apply to an offender who is serving a life sentence imposed as a minimum punishment, commuted from a sentence of death or serving a penitentiary sentence for an indeterminate period.

Chapter 6: Regional Distribution of Health Costs Associated with Seniors

The Committee has heard that labour force mobility has exacerbated the aging of the population in some jurisdictions, particularly Atlantic Canada. Because the costs of providing health care to seniors is higher than for other age groups, per-capita health funding through the Canada Health Transfer may eventually result in a widening gap in the basket of services provincial and territorial governments will be able to provide to seniors as the population ages. This chapter will examine options for addressing this issue.

The Committee recognizes that there may be other as yet unidentified options for addressing the regional distribution of health costs associated with seniors and welcomes discussion on those as well as the options outlined herewith.

6.1 Seniors and Health Care Costs

It is well documented that as people age, their use of the health care system increases. The Canadian Institute for Health Information (CIHI) reports that while seniors today are generally healthier than those of previous generations, they remain more likely than younger people to have chronic conditions and to suffer from poor health, and consequently also require and use more health care services.

This fact has important implications for the cost of delivering public health care in Canada. Health care expenditures, most of which fall under the jurisdiction of provincial and territorial governments, are significantly higher on a per capita basis for seniors than for the population as a whole.

Indeed, for most of a person's life, the cost of health care is relatively uniform. With the exception of the first year of a child's life, the average per capita cost to provinces and territories of providing public health services varies little from childhood through to about age 50. At that point, however, CIHI data show that costs begin to rise exponentially. From \$1,898 for Canadians aged 45-49, provincial and territorial expenditures on health services rise to \$5,412 per person for those 20 years older. For Canadians aged 85 and over, the average

cost of provincial/territorial government health care services was over \$20,000.

For many, the combination of an aging population and the increased cost of providing health care services to the elderly signals an impending crisis for the public health care system. It is frequently argued that as the average Canadian grows older, the burden on public health care spending will increase dramatically. Indeed, provincial and territorial government expenditures on health care are already growing at a rapid rate, rising by an average of 6% per person since 1999. These rising costs are seen by some as an early warning that the health care system as it exists today will not be able to withstand the pressures of an aging population.

This viewpoint persists in spite of a large body of evidence to the contrary. Several studies have concluded that the effects of population aging on public health care expenditures are, in fact, minimal; an aging population does contribute to rising health care costs, but its effects are modest.

If demographic trends are not a major driver of health care costs in Canada, then why are those expenditures rising? The two major factors behind this increase are inflation and the expansion of health care services. This expansion includes innovations and developments such as the increased availability of drugs, technological advances, improved surgery techniques, and an increase in the capability, and use, of diagnostic imaging equipment.

Moreover, while medical innovations can result in more effective health care treatment, in many cases improvements also lead to increased use of the health care system. Less invasive techniques, better drugs, improved diagnostic capabilities, and faster recovery times all increase demand for medical treatment. At the same time, as Canadians are living longer and healthier lives, many are in a better position to benefit from certain types of medical treatment. This is particularly true of seniors.

Hospital utilization rates and other instances of health care service use by the elderly have risen dramatically in recent years. For instance, in the five-year period from 2000-2001 to 2005-2006, total

angioplasties performed in Canada rose by 62%, knee replacements by 84%, hip replacements by 47% and cardiac surgeries by 33%.⁵

There is thus a critical distinction to be made between the effects of an aging population and rising consumption of health care services. While demographic change may not be a major driver of health care expenditures in and of itself, the amount and cost of health services demanded by seniors is increasing considerably.

In other words, it is not the aging of the population that is driving up health care costs in Canada, but rather, the fact that demand for health care services by seniors is increasing. The rise in per capita consumption of health care services by seniors accounts for about two thirds of the change in national health care expenditures over the past thirty years. Indeed, in the late 1990s, the provincial and territorial governments identified growing demand for health services by seniors as the basis for their request for additional financial support from the federal government under the Social Union Framework Agreement.

6.2 Demographic Projections for Provinces and Territories

The issue of growing demand for public health care services by seniors is complicated by the fact that there are differences in the age structure of the population across the provinces and territories. A number of demographic and socioeconomic factors have contributed to the fact that seniors represent a higher proportion of the population in some provinces compared to others. Moreover, demographic projections indicate that these differences will, for the most part, widen over time.

Differences in Population Age and Structure by Province

That the Canadian population is aging is well established. From 1971 to 2006, the median age in Canada – the age at which half the population is younger and half is older – rose from 26.2 years to 38.8 years. In 1971, 7.9% of the Canadian population was over the age of 65. In 2006, that was true of 13.1% of the population.

⁵ M. Lee, *How Sustainable is Medicare?: A Closer Look at Aging, Technology and Other Cost Drivers in Canada's Health Care System*, Canadian Centre for Policy Alternatives, Ottawa, September 2007.

However, the population is not aging at the same rate across Canada. There is a growing east-west divide, in which the populations of the five easternmost provinces are, in general, older and aging more quickly than the populations of the five westernmost provinces and the three territories.

A similar trend is evident when considering the proportion of seniors in each province. Alberta is by far the youngest province in Canada and also has by far the lowest proportion of seniors. While seniors made up 13.1% of the total population in Canada, they accounted for only 10.4% of the population in Alberta.⁶ Ontario is also home to a lower-than-average share of seniors, at 12.8%.

At the other end of the spectrum, Saskatchewan has the highest proportion of seniors at 14.9%, although, unlike all other provinces, this share is not growing; it has been relatively constant since the mid-1990s. Aside from Saskatchewan, the three Maritime Provinces have the largest proportion of seniors in their populations.

Differences in population age and the proportion of seniors across the provinces are the result of a combination of several factors. Perhaps the two most important of these are birth rates and inter-provincial migration trends.

High birth rates lower the median age of the population and also indirectly reduce the proportion of seniors in the total population. In Canada, birth rates are highest in the three Prairie Provinces, while the country's lowest birth rates are found in Newfoundland and Labrador, Nova Scotia and New Brunswick.

More significant is the impact of inter-provincial migration across Canada. Each year, about 1% of the Canadian population moves to a new province or territory. In 2005-2006, for example, nearly 333,000 Canadians are estimated to have changed their province or territory of residence. Although a 1% annual rate of migration may not seem significant, when multiplied over decades it can result in large population shifts across the country.

The general trend of inter-provincial migration is of young Canadians moving from poorer provinces to those where economic opportunities are greater. Since the early 1970s, there has been a

⁶ It should be noted that the proportion of the population over 65 is far lower still in the three territories: 7.5% in the Yukon, 4.8% in the Northwest Territories and 2.9% in Nunavut.

large net flow of inter-provincial migrants out of the Atlantic Provinces (except PEI), Quebec, Saskatchewan and Manitoba. Ontario, Alberta and BC have been the primary beneficiaries of these migration flows. Students and young working-age Canadians, those 20 to 39 years old, accounted for half of all migration in the past five years. Another quarter of inter-provincial migrants were under 20.

Demographic Projections through to 2031

Because of factors like inter-provincial migration and birth rates, differences in population age structure across the provinces and territories are expected to widen in the future. Statistics Canada has published data projecting provincial and territorial population, by age, through to 2031 under a range of growth and migration scenarios. According to figures under the conservative “medium growth, medium migration” scenario, seniors will represent a higher share of the overall population in all provinces in 2031 compared to 2006. However, the population of seniors is expected to grow faster in provinces where seniors are already more prevalent.

Nationally, seniors made up 13.1% of the population in 2006, a figure expected to rise to 23.4% by 2031. In Atlantic Canada and Quebec, however, the proportion of seniors is projected to be markedly higher in 2031, ranging from 25.3% of the total population in Quebec to 29.5% in Newfoundland and Labrador.

In the western provinces, demographic factors and migration patterns work in the opposite direction. Higher birth rates and/or an influx of migrants from other provinces are expected to slow the relative growth of the over-65 population. By 2031, the proportion of seniors in the western provinces is projected to range from a low of 21.4% in Alberta to a high of 24.9% in neighbouring Saskatchewan.

6.3 Consideration of Expenditure Needs in Federal Transfers

The average cost of delivering public health care services rises rapidly for Canadians over the age of 50. At the same time, migration trends and other factors are causing some provinces to age more rapidly than others. This combination represents a significant policy challenge for Canada.

Public health care is already the single largest area of expenditure for provincial and territorial governments. Nearly 40% of

provincial/territorial program spending is on health care. The fact that the population is aging more rapidly in some provinces suggests that the cost of delivering health care services will also rise faster in those jurisdictions. Moreover, many of the provinces in which the proportion of seniors is rising fastest are also among the poorest in Canada.

The provinces and territories receive financial assistance from the federal government to help offset the cost of providing health care and other public services. According to data from the Department of Finance Canada, the federal government provided transfers to other levels of government totalling \$43.5 billion in 2006-2007, equivalent to 19.6% of total federal budgetary expenditures. The vast majority of these funds (92.4%) are delivered through three major transfer programs – Equalization, the Canada Health Transfer (CHT) and the Canada Social Transfer (CST).

It has been suggested that the federal government consider adjusting its system of transfer payments to reflect differences in age-based expenditure needs across the provinces. The Committee has identified two broad ways in which this could be done. The first is by incorporating age-based expenditure needs into one or more of Canada's existing major transfer payment programs. The second is by creating a separate and distinct transfer to address that specific policy challenge.

There are a number of options for amending the existing transfer payments. These options and the option for creating a new transfer payment are outlined below. The options outlined below are not intended to be exhaustive. The Committee is welcoming input on these and any other options which might be identified.

Options for Incorporating Age-Based Expenditure Needs into Equalization

Equalization is a federal formula-based transfer program that helps to smooth out the differences in revenue-generating capacity across the provinces. On the surface it is intuitively simple - equalization provides annual cash payments to those provincial governments that have a relatively weak ability to generate revenues using the tax bases at their disposal. Equalization is governed by the principle that provinces should have access to sufficient revenues so as to be able to provide a reasonably comparable level of services at a reasonably comparable level of taxation.

Although the principle of equalization is simple, the program itself is complex. Through an established formula, equalization creates a Representative Tax System (RTS) which evaluates how much money each province could raise (on a per capita basis) if all provinces had the exact same tax rates. Each province's per capita total under the RTS is then compared with the average for all ten provinces. If a province's per capita total is below this standard, then, subject to some conditions, it qualifies for as much equalization as necessary to reach the standard.

Because equalization is formula-driven, the total cost of the program varies from year to year depending on the relative economic strength of the provinces. If the gap between rich and poor provinces falls, whether because of weakness in the former or strength in the latter, total payments fall. Conversely, if the gap between rich and poor provinces rises, again whether because of strength in the former or weakness in the latter, total payments rise.

However, equalization only addresses one half of the fiscal equation. It is silent on the issue of expenditure needs or the cost of delivering services. Once equalization entitlements are calculated, population size is the only direct determinant of the value of total payments.

There are three basic options for reforming equalization to account for differences in population age.

77- Reform the Existing Equalization Program

Perhaps the most straightforward way to incorporate age-based needs into the present equalization formula is to introduce a provision that adjusts per capita payments according to population age. For instance, for every resident over a certain pre-determined age, a province would receive a premium on its equalization payments. One example of such a program would be that provinces could receive 110% of their per capita equalization entitlement for every individual over the age of 65.

To incorporate such a reform would be easy to implement, but it comes with several drawbacks. Foremost among them is the fact that population age is already reflected in the equalization program as it exists today.

Equalization compensates provinces that, loosely speaking, have a below-average ability to generate own-source revenues. A province

with a proportionately large share of seniors would, all else being equal, already have lower revenue-generating capacity. Seniors earn about 80% of the total income of the average Canadian, meaning that a government's ability to raise income tax revenue is more limited in a province where seniors are more prevalent. A high percentage of retired seniors could also affect a province's fiscal capacity in other revenue fields, like payroll taxes, for example. These factors are already reflected in the equalization program as it exists today.

Moreover, the intent of equalization is to ensure that all provinces have access to a reasonably comparable level of revenues with which to finance government services. Considering the multitude of factors that affect provincial government finances, it might be difficult to make the case that special allowances should be made for age-based needs, but not other factors.

78- Introduce an Age-Based Expenditure Needs Component to Equalization

A second option is to introduce an age-based fiscal need component to equalization. Under such a program, a measure would be made of the relative cost of delivering a broad series of provincial government services by age range. Provinces which had a higher-than-average expenditure burden owing to the age structure of their population would then be compensated for this difference via the equalization program.

Under such a program, a province's total equalization payments would be a function of two considerations: its fiscal capacity relative to the other provinces; and the cost of providing services based on the age structure of its population relative to the other provinces. The positive and negative equalization entitlements that result from each would be added together to arrive at a final payment value.

A carefully-devised program which accurately calculated age-based expenditure needs would be an effective vehicle through which to compensate provinces where the cost burden associated with population age is higher. However, while creating such a mechanism is feasible, it would likely be quite contentious.

One problem is that it would be difficult for the federal government and the provinces to find agreement on how age-related costs are to be measured. Another is the fact that a balance must be struck between simplicity and comprehensiveness. Simple measures of age-based needs need not be costly or difficult to make, but that

simplicity often comes at the expense of accuracy. By contrast, it may be possible to design a thorough measure of age-based needs, but the expense in data collection and calculation could be formidable.

Witnesses appearing before the Committee offered two other concerns with the idea of incorporating age-based needs into the equalization program. If the number of seniors – or some other measure of population age – warrants consideration in the equalization formula, then the same could be said for provincial infrastructure needs, the number of university students or even snow removal costs.

In addition, there is an important distinction to be made between expenditure needs and the cost of providing services. A province like Newfoundland and Labrador, which has a large proportion of seniors, may have greater expenditure needs because it must provide more health services and long-term care facilities to seniors, for example. At the same time, however, while there are relatively fewer seniors in Alberta, the *cost* of providing those same services is higher because of factors like higher wages and salaries and the price of real estate. The province in which the fiscal burden is greater is not immediately obvious.

79- Introduce a Comprehensive Fiscal Needs Component to Equalization

Another way to incorporate age-based expenditure needs into equalization is to create a comprehensive equalization program – one which not only equalizes provincial revenue generating capacity, but all provincial expenditure needs as well. To the extent that population age affects the cost of delivering health, education, social services, and other provincial government services, these additional costs would then be reflected in equalization entitlements.

For the purposes of equalization, expenditure needs can be measured in one of three ways: by estimating the cost of providing a standardized set of public services; by using observed historical spending patterns and average costs for various expenditure types; or by creating a Representative Expenditure System (RES), an approach analogous to the RTS on the revenue side. This third approach is the most thorough and best captures the spirit and intent of the equalization program.

While a comprehensive RES is intuitively desirable, it is also considerably more difficult to set up and may lack the transparency of

a simpler approach. Indeed, creating an RES requires the following steps:

- Determining which categories of expenditures will be included;
- Determining, and differentiating, the influence of both cost and need on overall expenditures; and
- Creating a national standard against which to measure provincial spending in each expenditure category.⁷

In each of these steps, the capacity for disagreement with, and between, the provinces is considerable. Another issue with regard to creating an RES mechanism is the relationship between cost and need. While some may argue that the need for medical services is higher in provinces like Nova Scotia where the population is older, it is also true that the cost of providing services could be greater in wealthier provinces where wages and property values are higher. Both cost and need considerations should be included in any equalization program which considers provincial spending levels. However, the interplay between cost and need could have unpredictable results. In other words, it is possible that a detailed analysis of provincial government costs and needs could result in a *decrease* in equalization payments to recipient provinces.

In spite of these drawbacks, there is an intuitive appeal to a comprehensive equalization program. For many, ensuring that all provinces are capable of providing a similar level of public services requires some consideration of the relative cost of delivering those services across the country.

A number of countries around the world operate equalization programs that already incorporate some measure of expenditure need. The most notable example is Australia, which operates a detailed transfer program that considers 18 categories of revenue and 41 categories of expenditure.

Options for Incorporating Age-Based Needs into the Canada Health Transfer

The CHT is an unconditional transfer from the federal government to the provinces and territories intended to help offset the cost of providing health care services. The CHT was created in 2004

⁷ Vaillancourt, F., and Richard M. Bird, *Expenditure-Based Equalization Transfers*, ITP Paper 0512, June 2005, page 10.

when, in an effort to improve transparency and accountability, the former Canada Health and Social Transfer (CHST) was split in two, creating the CHT and the Canada Social Transfer.

The CHT is a two-part transfer. It consists of an annual cash payment and the nominal value (to each province) of a one-time transfer of tax room (in 1977) from the federal government to the provinces. The value of the tax room grows in line with the personal and corporate tax base, while the value of the cash component is determined in multi-year funding commitments.

The entire CHT is distributed on an equal-per-capita basis. However, the cash payment is the only *actual* transfer which takes place on an annual basis. The tax room vacated by the federal government over 30 years ago essentially acts as an offset to cash payments: since the total transfer is equal per capita, the higher the value of the tax points to a province, the less cash it receives.

For example, in 2007-2008, the total value of the CHT transfer was about \$1,054 per person. In Ontario, the tax point component of the transfer was worth \$425, while it was worth \$377 in Nova Scotia.⁸ As a result, Nova Scotia received higher cash payments – \$677 compared to \$629 in Ontario.

This method of distributing the CHT has been a long-standing point of contention between the provinces. While many provinces support the current method of distribution, some, like Ontario, have argued that all provinces should receive the same cash payments because the tax point transfer is strictly notional and has long been considered provincial own-source revenue.

In Budget 2007, the federal government announced its intention to move towards equal-per-capita distribution of CHT cash. However, because the government is in the midst of a 10-year funding commitment on health care, this move is not scheduled to begin until 2014-2015.

The transition to equal per capita cash transfers will be controversial. In order for all provinces to receive the same cash payments per person, those that receive lower payments today –

⁸ The value of the tax points to equalization-receiving provinces is equal to the combined value of the tax points themselves, as well as the equalization payments they receive on those tax points. As a result, the value of CHT tax points is nearly identical in provinces that qualify for equalization.

Alberta and Ontario – will have to be brought up to the level of the other provinces. This implies faster growth in CHT cash to the richer provinces, at least during the transition period. Poorer provinces interpret this transition as the federal government giving the most cash to those who need it the least. For the provinces that benefit, the increase in transfers simply rectifies a longstanding imbalance that has always favoured the poorer provinces. For its part, the federal government maintains that for poorer provinces, the recent changes to the equalization program – which have made that transfer more generous – should offset the slower growth in CHT cash transfers down the road.

The case for including age-based expenditure considerations into the CHT is perhaps stronger than the case for making related adjustments to the equalization program. Equalization is intended to help provinces afford to deliver a wide range of public services. By contrast, the CHT is targeted exclusively for provincial spending on health care service and, as described earlier, age is clearly a major determinant of public health care spending.

There are three broad options for how age-based needs could be incorporated into the CHT.

80- Weight Federal Health Contributions by Age

One option is to adjust the value of federal cash transfers to the provinces according to population age. This idea was proposed in 2002 by the Standing Senate Committee on Social Affairs, Science and Technology. In its report, *The Health of Canadians – The Federal Role, Volume Six: Recommendations for Reform*, that Committee recommended weighting federal health contributions to each province/territory by the proportion of its population over the age of 70.

There are some drawbacks to this option, however. For one, weighting federal health contributions by age is necessarily subjective. The federal government would have to make choices as to which age thresholds it would consider, as well as how heavily to weight them. In both cases, there are a multitude of possibilities, making agreement across the provinces and territories unlikely.

Another drawback is that this option does not address the issue of expenditure need versus cost. Age is but one determinant of public health care spending. Geography, population density, transportation costs, property values, wages and population health all factor in to the

cost of delivering public health services. If a special adjustment is made for age but not any other factor, has the CHT been made fairer as a result?

81- Create a Measure of Age-Based Expenditure Need

To create an appropriate measure of age-based expenditure need requires a mechanism that isolates the impact of population age on health care costs. Not only is age one of many determinants of health care spending, but also the amount spent by provinces and territories on health care is a function of policy choice as much as it is of expenditure obligations.

One relatively simple way to isolate the effects of age on health care spending is to create a standard expenditure rate at each age range and then use this measure (and not actual provincial expenditures) as the basis for determining the effects of population age on total costs. This approach is not unlike the equalization formula. In equalization, provinces are compared not on their *actual* revenues, but on how much revenue each could generate if all had the same tax rates. In this case, provinces would be compared on how much their health care expenditures would be (by age range) if their cost structure was the same at all ages.

A 2002 Library of Parliament publication, *Incorporating Age-Based Needs into Federal Health Transfers* examined how such a program could be created. The process it outlines can be expressed through a series of questions (using Nova Scotia as an example):⁹

- 1) Using the national average health care expenditure rates, what are provincial health care expenditures by age in Nova Scotia?
- 2) If the population age structure of Nova Scotia was identical to the national average, what would provincial health expenditure requirements be, by age range?
- 3) At each age range, what is the difference between 1) and 2)?

In essence, this option works to isolate the effect of a province's age structure on health care costs. If its age structure creates an additional cost burden, then, like the equalization program, that province would qualify for federal health transfers to compensate for the difference.

⁹ M. Holden, *Incorporating Age-Based Needs into Federal Health Transfers*, PRB 02-53, Parliamentary Information and Research Service, Library of Parliament, Ottawa, December 2002.

The most significant advantage to this option is that it incorporates age-based needs into health transfers in a policy-neutral way. The spending decisions of an individual province do not affect the amount of CHT transfers it would receive, except to the extent that one province affects the national average. This option also effectively isolates the impact of population age on provincial health care expenditures, independent of other considerations and does so in a relatively objective manner. Finally, by using national average health expenditures, it would not be necessary for the federal government to broach the contentious issue of finding an appropriate measure of age-based costs.

Although this funding option improves on some of the shortcomings of previous options, drawbacks remain. Because it mimics the equalization program, it could be subject to some of the same criticisms: complexity and a lack of transparency. Moreover, it does not address the fact that, once again, age is the only health-related cost factor to merit special compensation.

82- Introduce a Comprehensive Needs-Based Approach to Health Transfers

A final option is to include population age in a comprehensive measure of expenditure needs and cost pressures, one that takes into account all the major factors which affect provincial health care expenditures. This option is similar to the idea of creating a representative expenditure system for the equalization program, except that in this case, the representative expenditures would be limited to those in the area of health care spending.

As such, most of the advantages and disadvantages described in the equalization section apply here as well. The most significant advantage to creating a broad-based formula to estimate expenditure need in health care is that, if constructed carefully, it would reflect *all* the expenditure needs and cost pressures facing health care spending across the provinces and would distribute federal health transfers accordingly. Provided that there was widespread agreement from all stakeholders about how costs and needs were to be measured, such a transfer program would address the concerns of provinces with a rapidly-aging population, as well as those of provinces where the cost of delivering public health care is high for other reasons.

However, agreement would be difficult to achieve. Given that a host of indicators could be used to measure provincial and territorial health spending requirements, ranging from broad macro data like

average life expectancy, to the incidence of specific ailments, to detailed information about waiting times for certain types of surgeries, provincial/territorial governments are unlikely to reach a consensus on what the best approach should be.

A related concern is data collection. Not all provinces and territories gather the same information on health care, or necessarily use the same methodology to do so. The costs associated with standardizing data and arriving at a comprehensive formula to measure health care expenditure needs may be too high to be worthwhile.

Moreover, even if agreement could be reached on a way to measure expenditure needs for public health care, there is no guarantee that the end result would be more funding for provinces with a higher proportion of seniors. When age is lumped together with other cost and need considerations, it is conceivable that provinces with older populations could receive *less* than an equal-per-capita share of federal health transfers because the effects of these other factors could outweigh the additional expenditure needs associated with a higher proportion of seniors.

83- Reform the Canada Social Transfer to Include Age-Related Costs

The Canada Social Transfer is, in essence, the smaller twin of the CHT. While the CHT is intended to support provincial and territorial expenditures in health care, the CST is a block transfer in support of provincial and territorial government spending on post-secondary education, social assistance, and social services, including early childhood development, early learning and child care.

Until recently, the structure of the CST was identical to the CHT – the total transfer entitlement was a combination of notional tax points and cash, the sum of which was distributed on an equal-per-capita basis. However, it was announced in Budget 2007 that the federal government would move towards an equal-per-capita distribution of CHT and CST cash. While the change in the distribution of CHT funds is not expected to begin until 2014-2015, the CST became an equal-per-capita cash transfer in 2007-2008. The total value of cash payments that year was just under \$9.5 billion. Beginning in 2009-2010, CST cash will grow by 3% per year through to 2013-2014.

In an effort to improve transparency, the federal government also announced in Budget 2007 that it will provide information on the distribution of cash transfers within the various components of the CST. It is important to note, however, that the CST remains an unconditional transfer. Provinces and territories are free to spend the transfer as they wish.

For the most part, the CST is not pertinent to the expenditure needs associated with a population that is aging unevenly across Canada. Many of the programs supported by the CST are intended for younger Canadians. About 40% of CST cash in 2008-2009 is intended for spending on post-secondary education and support for children. The remaining \$6.2 billion is nominally earmarked to support provincial and territorial social services programs such as welfare. It is only to the extent that seniors qualify for these programs, or that senior-specific social programs exist in the provinces and territories, that the CST is relevant to the discussion at hand.

In fact, the notion that the distribution of CST transfers could be adjusted to reflect differences in population structure weakens the case for adjusting CHT transfers in a similar manner. If it can be argued that Quebec and the Atlantic Provinces are entitled to a greater share of CHT funding because seniors are more common in those provinces, then it could be argued with equal justification that Alberta, Saskatchewan, Manitoba and the three territories should receive a greater share of CST funding because they have a higher-than-average proportion of the population under the age of 30.

While it is true that the CHT is a considerably larger transfer than the CST, the net effect of a redistribution of transfers according to age-based needs is less than clear. It is for this reason, in fact, that federal transfers to the provinces and territories tend to be distributed on an equal-per-capita basis. Given the host of factors that affect costs and spending needs – not to mention the policy choices of individual governments – the equal-per-capita distribution of transfers is, for many, the most equitable approach.

CST transfers are only faintly pertinent to the fact that provinces which are aging at different rates face diverging expenditure burdens. For this reason, it may not be appropriate to offer recommendations on adjusting the distribution of this particular transfer.

However, several organizations have suggested that the transparency of CST payments could be improved. Specifically, they recommend that the CST be split into two transfers – one explicitly in

support of post-secondary education, and one for social programs and social assistance. Endorsing this view is an option for the Committee. For the most part, post-secondary education financing is not a relevant issue for seniors. By contrast, social assistance, welfare and poverty reduction are most certainly important issues affecting seniors. Splitting the CST in two would isolate the federal transfers that are most relevant to seniors and make it easier for seniors and other stakeholders to seek improvements in federal support in those areas.

84- Introduce a supplementary Program to Compensate Provinces for Uneven Aging

Instead of making changes to existing programs, it has been suggested that Canada introduce a new transfer program explicitly designed to address differences in population aging across the provinces. This idea was better received by witnesses, many of whom were opposed to making fundamental changes to Canada's existing system of federal-provincial transfers.

A direct transfer in support of provinces with a faster rate of population aging has several advantages. For one, because such a transfer would be separate from Canada's existing federal-provincial transfers, the role and purpose of each would be clear and transparent, preserving efficiency and accountability. Second, while public health care is perhaps the most important area where expenditure needs will vary across the provinces and territories, there are others as well. A transfer devoted to differences in population aging would allow for all age-related cost pressures to be reflected.

Finally, it was argued that it makes little sense to modify existing transfer programs for a temporary phenomenon. The Committee heard that the cost pressures associated with population aging will peak in the 2030s and then slowly fall back.

While there are ways in which existing transfers could be modified to reflect age-based expenditure needs, any such changes would likely be complex and controversial. The simplest and most straightforward way to help provinces with the costs associated with a population that is aging more rapidly might be to provide a separate and distinct transfer payment for that purpose.

List of Proposed Options

- 1- Provide tax credits for volunteerism
- 2- Ensure multi-year funding for volunteer activities
- 3- Invest in infrastructure for volunteer organizations
- 4- Initiate a skills matching program
- 5- Promote and recognize volunteerism throughout the life cycle
- 6- Expand educational tax credits
- 7- Support a life-long learning website
- 8- Carry out a life-long learning awareness campaign
- 9- Adapt New Horizons for Seniors for Aboriginals
- 10- Reduce isolation through better urban planning
- 11- Educate Canadians about the benefits of physical activity
- 12- Eliminate barriers which limit active living
- 13- Facilitate the sharing of knowledge and best practices
- 14- Launch a national strategy to combat ageist stigma and discrimination
- 15- Promote the development of alternatives to chronological age as indicators of competency
- 16- Promote research on competency
- 17- Launch an awareness campaign on the recent legislative changes that removed barriers to phased retirement
- 18- Restore the actuarial neutrality of Canada Pension Plan by increasing the incentive to delay uptake
- 19- Work with the provinces to change the Canada Pension Plan so that older workers who begin to collect CPP before age 65 continue to contribute to the CPP
- 20- Work with the provinces to change the Canada Pension Plan so that individuals between the ages of 60 and 65 who want to apply for CPP and continue working no longer have to quit work or earn up to the maximum of CPP in the months prior to the application
- 21- Undertake both an awareness campaign against discrimination against older workers and more aggressive scrutiny of the treatment of older workers for compliance with existing legislation and regulations
- 22- Amend the Employment Insurance program to provide benefits to unemployed older workers, rather than forcing early reliance on CPP or other pensions that may penalize for early withdrawal
- 23- Explore options for other forms of income streams
- 24- Make OAS/GIS benefits non-taxable if they are the only source of income

ISSUES AND OPTIONS FOR AN AGING POPULATION
LIST OF PROPOSED OPTIONS

- 25- Propose to provincial governments that survivor's benefits under CPP be sustained at the same level after the death of the spouse
- 26- Modify GIS to keep seniors from dropping below low-income cut-off lines
- 27- Work with provincial governments to increase the income replacement rate for the CPP (currently 25% of income up to the average wage) and/or to increase the maximum pensionable earnings beyond the average wage
- 28- Analyze any changes with respect to retirement income to assess and correct for differing impacts on men and women
- 29- Undertake more aggressive campaigns to ensure that all eligible Canadians are receiving all retirement- and age-related benefits
- 30- Make retroactive repayments with interest to eligible recipients who did not apply for OAS at 65 or CPP at 70, or who were denied benefits due to administrative errors and make these payments cover the period between the ages specified and the age at which repayment is made
- 31- Harmonize the design and operations of Old Age Security and the Guaranteed Income Supplement and supports and services (largely provincial) so that modest increases in income do not result in a reduction of supports or services
- 32- Develop a federal/provincial/territorial accord to ensure that increases in OAS and/or GIS do not result in loss of eligibility for subsidies or services for seniors
- 33- Reconsider the design of CPP in light of increasing variations in labour force participation
- 34- Establish a national comprehensive publicly-insured or publicly-privately-insured prescription plan
- 35- Introduce public information campaigns about nutrition, targeted at seniors and the general population
- 36- Ensure that the dental care programs for First Nations and Inuit, veterans, and inmates in federal facilities cover the costs of dentures
- 37- Develop supports for caregivers and promote education to prevent burnout
- 38- Improve training for the continuum of human resource workers on seniors' needs
- 39- Share best practices on the prevention of elder abuse
- 40- Sign the Hague Convention on the International Protection of Adults
- 41- Support capacity building projects for training in geriatrics and gerontology
- 42- Implement a funded national partnership on palliative care

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LIST OF PROPOSED OPTIONS

- 43- Implement a public education program to inform Canadians about end-of-life services and the need for advance care planning
- 44- Increase training and education opportunities surrounding palliative and end-of-life care for health professionals and volunteers
- 45- Apply the gold standards in palliative home care to veterans, First Nations and Inuit, and federal inmates
- 46- Develop tools to facilitate the early diagnosis of mental health conditions
- 47- Remove the 3 percent cap on NIHB health services
- 48- Expand eligible expenses under the Non-Insured Health Benefits Program to include the cost of foot care
- 49- Ensure that senior inmates in correctional facilities receive necessary support aids in a timely fashion
- 50- Increase publicity about CMHC home adaptation programs
- 51- Increase the stock of affordable housing across the country
- 52- Increase the availability of vouchers to allow low-income seniors to pay for adequate housing
- 53- Ensure that the standards for barrier-free design that are already contained in the *National Building Code of Canada* are consistently met by builders or enforced by inspectors
- 54- Increase the stock of affordable supportive housing
- 55- Increase the supply of affordable supportive housing for First Nations and Inuit seniors
- 56- Improve the regulation of supportive housing across the country
- 57- Facilitate access to information about housing options across the country
- 58- Encourage the provinces and territories to make reciprocal arrangements to eliminate the waiting period for residents from another province
- 59- Communicate information and best practices about adapting long-term-care facilities to address the needs of a multi-cultural society
- 60- Introduce a National Home Care Program
- 61- Address the uneven qualifications and conditions of work of home care staff
- 62- Create a registered chronic care savings plan
- 63- Provide information to caregivers
- 64- Create a National Respite Program
- 65- Make Changes to the Compassionate Care Benefit
- 66- Provide financial support to caregivers
- 67- Introduce a Canada Pension Plan (CPP) drop-out provision for caregivers

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LIST OF PROPOSED OPTIONS

- 68- Introduce a National Policy Initiative for Integrated Care
- 69- Share of best practices related to integrated care
- 70- Create a needs-based 'Seniors Independence Program' for all Canadian seniors, modelled after the Veterans Independence Program (VIP)
- 71- Expand the Veterans Independence Program to all Canadian Forces veterans
- 72- Increase the stock of adequate and affordable housing for First Nations and Inuit
- 73- Provide First Nations and Inuit with the same package of services available to war service veterans in the VIP program
- 74- Implement the recommendations contained in the Correctional Service of Canada's (CSC) *Report on Elderly Offenders*
- 75- Amend the Corrections and Conditional Release Act by adding offenders who are elderly or who have serious health problems to the list of offender groups with special needs
- 76- Amend the Corrections and Conditional Release Act to make terminally ill offenders serving life sentences or indeterminate sentences eligible for parole on compassionate grounds
- 77- Reform the Existing Equalization Program
- 78- Introduce an Age-Based Expenditure Needs Component to Equalization
- 79- Introduce a Comprehensive Fiscal Needs Component to Equalization
- 80- Weight Federal Health Contributions by Age
- 81- Create a Measure of Age-Based Expenditure Need
- 82- Introduce a Comprehensive Needs-Based Approach to Health Transfers
- 83- Reform the Canada Social Transfer to Include Age-Related Costs
- 84- Introduce a supplementary Program to Compensate Provinces for Uneven Aging

Witness List – 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.

WITNESS LIST

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.

Witness List – 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.

WITNESS LIST

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.

WITNESS LIST

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;

Maria Wilson, Project Coordinator.

Pauktuutit Inuit Women of Canada

Jennifer Dickson, Executive Director.

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.

ISSUES AND OPTIONS FOR AN AGING POPULATION
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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.