Special Senate Committee on Aging
First Interim Report

Embracing the Challenge of Aging

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

March 2007

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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
Jane Cordy
Terry M. Mercer
Lowell Murray, P.C.

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 Senator Janis G. Johnson also participated in this special study.

Staff from the Parliamentary Research Branch of the Library of Parliament:

Julie Cool, Analyst
Michael Toye, Analyst
Howard Chodos, Analyst

Monique Régimbald
Administrative Assistant

François Michaud
Clerk of the Committee

Order of Reference

Extract from the Journals of the Senate of Tuesday, November 7, 2006:

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

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

That, notwithstanding rule 85(1)(b), the Committee comprise seven members, namely the Honourable Senators Carstairs, P.C., Chaput, Cordy, Johnson, Keon, Mercer, and Murray, P.C., 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 Aging;

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

That the Committee have power to send for persons, papers and records, to examine witnesses, to report from time to time and to print

such papers and evidence from day to day as may be ordered by the Committee;

That the Committee have power to adjourn from place to place within Canada;

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 Order of Reference to the Standing Senate Committee on Social Affairs, Science and Technology concerning the aging of the population, adopted by the Senate on June 28, 2006, be withdrawn; and

That the Committee present its final report to the Senate no later than December 31, 2007, and that the Committee retain all powers necessary to publicize the findings of its Final Report until March 31, 2008.

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

Paul C. Bélisle

Clerk of the Senate

Introduction

> **"We have a choice as a society: Either to buy into the myths that seniors will drain the health and pension systems, for example, or to take advantage of the reality that seniors can contribute to society."[1]**

Predictions of an "age quake" have gripped the collective consciousness, warning of an impending inability to maintain current levels of public support to health and income. The Committee has heard evidence to the contrary, however. While the retirement of the baby boom generation is likely to have important consequences for the labour market, this will not necessarily lead to a reduction in the standard of living. Several witnesses reassured the Committee that the "sustainability of government programs is not really in doubt."[2]

The Committee views population aging as a success story and seniors as a rich and vibrant part of our country. As we increasingly draw on seniors to meet labour force requirements strained by decades of low fertility, our society has new motivation to value seniors as contributing members of society, and not as burdens to be problematized. At the same time, it is necessary to provide the services and supports which will allow seniors to live with dignity.

The Committee highlights that all generations stand to benefit from effectively addressing seniors issues. The Committee has been cautioned against viewing the experiences of disability, illness and death which are so commonly associated with aging as "seniors' issues". The Committee recognizes that the final years of life present a myriad of challenges to individuals, their families, and the health and social systems – however this is the case whether those final years occur in youth, in the middle years, or in the senior years. Thus, while issues such as end-of-life care, home care and accessible transportation are explored in this study, and while successfully

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1 Judy Cutler, CARP – Canada's Association for the Fifty-Plus, Evidence, December 11, 2006.

2 Byron Spencer, McMaster University, Evidence, November 27, 2006.

addressing these issues will have important repercussions for seniors, the Committee points out that progress in addressing these complex issues has the potential to benefit Canadians of all ages. As one witness said, "… healthy aging does not start at 65; it starts the day that one is born. The chronic condition does not start when one turns 65. It has its roots in the 30s and 40s.[3]

The mandate conferred upon the Special Senate Committee on Aging by the Senate of Canada requires that the Committee address 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 is to 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.

The Committee has adopted a dual approach to this study - on the one hand, challenging the assumptions we have of seniors and aging and exploring alternate ways of organizing society to better meet the aspirations of all; on the other hand, examining how public policies can and should support the ability of all seniors to live in dignity. In carrying out its study, the Committee is mindful of the federal role in helping Canadians age well. It intends to draw on international experiences with population aging and review Canada's role on the international scene.

To fulfill its mandate, the Committee opted to divide its study into two phases: a brief overview of key issues to identify key questions, followed by a more thorough second phase to explore those questions in greater depth. The Committee began Phase One of its study on aging by holding five panels with leading experts, seniors organizations and representatives of relevant federal government departments and agencies. These panels served to open the doors to new questions, new ways of looking at things, and to challenging some of the commonly held beliefs about aging.

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[3] Sandra Hirst, Canadian Association of Gerontology, Evidence, December 11, 2006.

This interim report marks the end of Phase One of the committee's study. Part 1 of this report identifies four broad themes to guide the Committee's work during Phase Two. This section of the report poses a series of questions along the themes of defining seniors, the diversity of seniors and their needs, defining a policy approach and determining the role of the federal government. An examination of these key questions will inform a review of 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.

Part 2 of this report provides a summary of evidence the Committee has heard up to December 2006 on the demographic profile of seniors in Canada today and highlights how that picture is likely to change in the future. It raises questions about the diversity within the aging population and how that affects the needs of the population. Finally, it identifies key issues which were consistently discussed by witnesses in Phase One: active participation of seniors in society and the economic life of their communities, healthy aging, and the range of support services to more fragile seniors.

The Committee views the aging population as an opportunity – an opportunity to rethink how we balance work, family, and leisure throughout the life-course and an opportunity to re-examine the way we view and value the experiences of seniors. We have before us a great challenge, but one filled with possibility.

Part 1: Defining the Issues

1. The Challenge of Population Aging

Under its terms of reference, the Committee is to 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. The Committee has begun to hear, however, that some of the gaps that exist in meeting the needs of today's seniors may be emerging as a result of outdated assumptions which are less relevant to today's seniors. Witnesses reminded the Committee that aging is not a process which is the exclusive domain of the 65+ group, but is a lifelong process. As such, they invited the Committee to adopt a holistic approach to aging which explores experiences and well-being throughout the life-course.

The Committee has adopted a dual approach to this study - on the one hand, challenging the assumptions we have of seniors and aging and exploring alternate ways of organizing society to better meet the aspirations of all; and on the other hand, examining how public policies can and should support the ability of all seniors to live in dignity. In carrying out its study, the Committee is mindful of the federal role in helping Canadians age well. As part of its review, the Committee intends to draw on international experiences with population aging.

The social and economic consequences of population aging have loomed over policy debates for the past decade. In part, this was fuelled by discussions of the affordability of pension systems in other countries. Some commentators have predicted fiscal pressures emerging from the increased need for health and social services for the elderly and a shrinking labour pool resulting from the retirement of the baby-boom generation. The main concern with an aging population has been that there may not be a sufficiently large working-

age population to support "dependents," including children and seniors. Proposed solutions to deal with this imbalance affect all segments of the Canadian population, not only seniors. Solutions range from policies to increase the fertility rate, to strategies for increasing labour force productivity, and efforts to avoid labour force shortages through immigration.

The majority of witnesses appearing before the Committee in Phase One of the Committee's study, have argued that the sustainability of the public pension system and the health system are not in jeopardy in Canada, and that the labour force implications of population aging can be mitigated by increases in productivity. The testimony of Professor Byron Spencer is representative of the testimony the Committee heard on this question:

> **"Government programs will remain manageable, at least in response to population aging. … The popular view is that increases in health care costs, which everybody thinks are obviously attributable to population aging, will break the bank – and, in particular, break government budgets – and things will be quite unmanageable. I think this simply is not true. It is not true of public pension programs, income security programs, and it is not true of health care programs."[4]**

To this end, the Committee has heard that "Canada has a much lesser concern with population aging than most already prosperous countries."[5]

But that is not the end of the story. The population is not aging at the same rate across the country. Not all older Canadians have the same access to goods and services or the same choices available to them regarding their care, housing, and ability to participate as active members of society. The life expectancy for our aboriginal peoples is substantially below that of non-aboriginal peoples. Urban and rural areas face different challenges in supporting senior populations as the decreasing and aging population in rural areas presents difficulties in

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4 Byron Spencer, McMaster University, Evidence, November 27, 2006.

5 *Ibid.*

maintaining services. Some segments of the senior population such as single seniors, immigrants, and the very frail face particular challenges.

The challenge for the Committee is to determine if we are delivering the right programs and services to the right individuals at the right time. As it begins the next stage of its study, the Committee will explore the following four themes: defining seniors; the diversity of seniors and their needs; determining the policy approach; and the role of the federal government. An examination of the key questions under each of these themes will then inform a review of 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.

1.1 Defining "Seniors"

> **"It is obvious to everyone who was around in 1951 that a 65-year-old at that time is not the same as a 65-year-old in 2006. They are different people. They are, on average, much healthier nowadays and certainly have many more years of good health ahead of them. I think it makes sense to change the definition — what we deem to be, for legal purposes and for age of eligibility for full benefits under social security and so on — in a systematic way as life expectancy increases, assuming life expectancy continues to increase as we may reasonably expect."[6]**

Seniors are widely understood in Canada to be persons over the age of 65 – but why this age? How well does this definition serve seniors? This question was the source of much discussion by witnesses appearing before the Committee.

The age of 65 has special significance for public policies relating to aging in Canada because it represents the current age of eligibility for

6 *Ibid*.

national income security programs[7] and, in jurisdictions which still allow mandatory retirement, it remains the age beyond which employees are no longer protected against discrimination based on age.

On the one hand, the use of age criteria for eligibility purposes provides policymakers with a transparent and seemingly objective standard.[8] Entitlement to public pensions has resulted in significantly lower rates of poverty for people in the 65+ age bracket than for those in other age brackets. On the other hand, the age threshold has been criticized for lending itself to negative stereotypes which have "sanctioned the retirement of elderly citizens from social and economic activity."[9]

The Committee has heard that the use of the chronological age of 65 by demographers and administrators of public pensions reflects a societal choice made within an historical context. In Canada, as in most industrialized societies during the postwar period, the establishment of the welfare state included a range of social programs to improve the living conditions of the elderly. Governments in industrialized nations established an age of retirement, and an age of entitlement to old age benefits, "thus engendering an administrative approach based on a formal association between entry into old age and this chronologically fixed age."[10]

Age-related entitlements for seniors date to the late 1800s in Germany, when German Chancellor Otto von Bismarck established 70 as the age when benefits could begin. As the Committee heard, very few people lived long enough to receive benefits at that time. While the age of eligibility had been reduced to 65 in the United Kingdom

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7 The age of eligibility for the Old Age Security pension and the Guaranteed Income Supplement is 65. Under the OAS program, a surviving spouse or common-law partner between 60 and 64 years of age who meets the income threshold is eligible for the Allowance for the Survivor.

8 Breda, Jef and David Schoenmaekers, "Age: a dubious criterion in legislation", *Ageing and Society*. (2006), 26: 529-547.

9 Ulysse, Pierre-Joseph for the Division of Aging and Seniors, Health Canada, *Population Aging: An Overview of the Past Thirty Years: Review of the Literature*. 1997.

10 *Ibid*., p.i.

and in Continental Europe by the 1920s, the setting of the age of eligibility for benefits in the United States at age 65 took place in the 1930s at a time when unemployment was rampant and jobs needed to be liberated for the next generation.

Until the late 1960s, the age of eligibility for Old Age Security (OAS) in Canada was set at 70. Canadians nearing retirement in the 1960s had lived through the Great Depression of the 1930s and the war years of the 1940s and had limited opportunity to save for their retirement. Faced with high levels of poverty among seniors, the Canada Pension Plan (CPP) was established in 1966 to provide working Canadians and their families with income for retirement. The age of eligibility for CPP, initially set at age 68, was gradually reduced to age 65 by 1970. The age of eligibility for OAS was also gradually lowered to 65 from 70 between 1966 and 1970.[11]

The age 65 was also set as an age at which employment could be terminated based on age, through mandatory retirement policies. Gradually, these policies have been challenged and found to be discriminatory under human rights legislation in several jurisdictions. Moving away from clearly defined age-based retirement criteria raises a number of complex challenges, however, such as determining the ongoing competency of senior workers.

While the age of 65 has been retained in Canada, the Committee heard that there are international variations in the definition of old age:

> **"The U.S... has redefined the age of eligibility for full benefits under its social security system to increase up to age 67 over a period of some years. That change is under way; it is happening bit by bit. As it does, in effect, they are redefining "old." In Sweden, the age of eligibility for socially provided pension**

[11] *An Information Paper for Consultations on the Canada Pension Plan*. Released by the Federal, Provincial and Territorial Governments of Canada, 1996. www.fin.gc.ca/cpp/maindoc/cppe.pdf

> **benefits is also indexed to increases in longevity, so it is increasing."[12]**

The evolution of the age of eligibility for seniors' benefits demonstrates that this age reflects a societal choice, made within a socio-economic context. The Committee has been urged to consider the potentially ageist impacts of continuing to depend on an age-based (as opposed to based on ability, health status, etc.) definition of benefits for seniors and to consider whether the set of assumptions upon which the choice of age 65 was established as the age of eligibility need to be revisited in light of the current socio-economic context and the health and well-being of seniors today. Statistically,

> **"In 1971, in Canada, 8 per cent of the population was 65 and over…Today, 8 per cent of people at the top of the age pyramid, made up of people who are in their last period of life, are 81 years old. This gives you an idea of the incredible progress that has been made as far as mortality is concerned."[13]**

The Committee will examine whether the age thresholds set in the 1960s still reflect the economic and social realities of old age today. At the same time, it is mindful that the move from age-based criteria will entail complex policy decisions, such as evaluating job-related competencies. The Committee will inquire further into questions such as:

- Should age define eligibility for access to programs?
- Does the current definition of seniors as those over the age of 65 still serve seniors, employers, and the rest of society?
- Is it consistent and valid that policies discriminate based on age?

1.2 Diversity of Seniors

> **"Seniors are not a monolithic group of poor, frail, sick or dependent persons. The 65-plus group**

[12] Byron Spencer, McMaster University, Evidence, November 27, 2006.

[13] Laurent Martel, Statistics Canada, Evidence, November 27, 2006.

> **presents considerable diversity in terms of life experiences, economic status, health status and resources for independent living."[14]**

People over 65 are not a homogenous group. The experiences of people in their senior years vary with available resources, quality of health, and degree of integration into social and family networks. The senior years are experienced differently by different segments of the population, based on age category, urban/rural residence, and gender, as well as culture and race. It has been suggested that basing programs and policies on age criteria can inadvertently lead to ageism, whereby the variation among seniors is dominated by assumptions about the homogeneous nature of their age group.

With recent gains in life expectancy, an increasing number of Canadians are living longer and are in better physical and mental health. Witnesses have pointed out the importance of recognizing the differences between different age groups of seniors:

> **"The difference between a 65-year-old and a 90-year-old is 25 years. There is a difference between someone who is 25 and someone who is 50. Why put those two people together in the same category? Their needs are very different, and we need to think differently about those groups."[15]**

Douglas Durst also noted that literature on seniors often refers to three broad age categories that should be distinguished: 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. While these age brackets may vary as a result of a myriad of factors intervening over an individual's life course, the recognition of the different stages of life with their corresponding levels of capability and needs can serve as a useful lens when considering persons over the age of 65.

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14 Robert Dobie, National Advisory Council on Aging, Evidence, November 27, 2006.

15 Douglas Durst, University of Regina, Evidence, November 27, 2006.

Seniors living in rural and urban settings have different needs. For example, transportation and housing options are often different for those in a rural setting than for those in an urban setting. As well, the effect of aging on the labour force and on health care may vary due to regional disparities in the pattern of aging of the population.

The Committee has heard disturbing evidence that Aboriginal Canadians have significantly lower life expectancy than their non-aboriginal counterparts. A couple of authors have suggested, "when thinking about Aboriginal First Nations seniors and aging, to think about 55 as being equivalent to 65 and that we ought to be looking at providing services and programs for a younger chronologically aged group for seniors due to the health and social conditions, diabetes, and so on."[16] The needs of our aboriginal population vary from that of the non-aboriginal population.

The implications of population aging are difficult to predict, in part because different groups of seniors have distinct life experiences, levels of well-being, and expectations. Thus, while it is clear that there will be proportionately more seniors in the next few decades, policy-makers are challenged by anticipating the potentially different needs and desires of future individuals who are 65+. This places increased importance on the need to periodically examine the validity of some of the assumptions which currently underlie seniors programs and policies in Canada.

Given the above, the Committee will want to examine whether the programs and services offered to seniors reflect the needs of a diverse population. Specific questions that bear deeper examination might include:

- Do current federal programs address the diverse needs, circumstances, and aspirations of the senior population?
- Do they reflect the different realities between genders?
- Do they reflect different kinds of employment patterns (eg. time out of paid employment for caregiving or education) and occupational groups (e.g. administrative or trades)?

16 *Ibid*.

- Do they reflect regional disparities and different patterns of aging in various areas of the country, and do F/P/T financing arrangements reflect these disparities?
- Is age 65 a realistic age of eligibility for Aboriginal seniors and other vulnerable Canadians to access programs?

1.3 Policy Approaches to Aging: Active Aging and Social Determinants of Health

"There can be a tension between a policy agenda centring on aging and an agenda centring around seniors. They are not the same thing."[17]

"Active ageing[18] applies to both individuals and population groups. It allows people to realize their potential for physical, social, and mental well being throughout the life course and to participate in society according to their needs, desires and capacities, while providing them with adequate protection, security, and care when they require assistance."[19]

"Healthy aging depends on a variety of influences or determinants that surround individuals, families, and nations. At times we talk about older persons as a separate cohort. Older persons, like all of us here aging today, are part of a community. Understanding the evidence behind these determinants; the economic, health and social services, behavioural, social, personal and physical, helps us to design policies and programs."[20]

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17 Peter Hicks, Human Resources and Social Development Canada, Evidence, December 4, 2006.

18 The United Nations uses the spelling "Ageing".

19 United Nations – World Health Organization, *Active Ageing: A Policy Framework,* 2002.

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

Witnesses before the Committee have made a distinction between addressing population aging and a seniors' agenda. For example, the proposed solutions to address population aging, such as policies to increase labour force productivity or to increase the birth rate – are initiatives which are distinct from those which might appear in a seniors' agenda.

The "life-course approach" or "active aging" models used by federal government departments and international organizations such as the OECD, are examples of an integrated perspective on aging. A life-course approach to aging considers important life transitions such as education, family formation, and retirement in order to find policies that facilitate these transitions through programs such as parental leave, life-long learning, and phased retirement. The World Health Organization has adopted the term "active aging" to describe the process of optimizing opportunities for health, participation, and security in order to enhance quality of life as people age.[21] Promoting active aging requires an understanding of what different groups of seniors want and facilitating the roles they choose to play in paid employment, volunteering, caregiving, and leisure. Opportunities to remain physically and mentally active are instrumental to the well-being of senior Canadians, whether in recreational activities, life-long learning, or volunteering.

Jane Barratt of the International Federation on Ageing emphasized the importance of this approach in her testimony before the Committee:

> **"After canvassing the aging policies and programs for many different countries not unlike Canada and reflecting on the work of our NGO members who represent 50 million older people in the world, I ask myself the question: What is the single-most broad policy intervention that could in some way impact on each of these substantive issues? The answer is "healthy aging." My caveat to this term is that aging -- that is, growing old -- is not a health issue,**

[21] United Nations – World Health Organization, *Active Ageing: A Policy Framework,* 2002.

> **nor should we see it as a health issue in the future, but rather part of the life-course approach. I have a belief that aging starts at birth and throughout the life- course we experience changes in our life, and at times we need specialist services and care."** [22]

Consideration of the distribution of work throughout the life-course is not new. The 1966 report of the Special Senate Committee on Aging phrased the challenge this way:

> **"How do we propose to share the leisure the new technology puts at our disposal? Should we give it mainly to the old by reducing the age of retirement in circumstances where the life span is lengthening, and to the unemployed who are squeezed out of the labour market? Or, would a more constructive policy be to distribute it among people of all ages through a shorter work week and longer vacations, with sabbatical leaves to workers throughout their careers for the purpose of continuing education and re-training?"[23]**

The 1966 Senate Committee concluded that it "would strongly support the second of these alternatives, or at any rate, such a mixture of the two as would permit workers at the point of retirement an effective choice between remaining in or withdrawing from the labour market."[24]

In his presentation to the Committee, Peter Hicks warned that "unless one is careful, aging might quite unintentionally lead to ageist thinking, as opposed, for example, to a policy framed under a broader life-course agenda."[25] Expectations of imminent retirement for older workers allow those workers, and their employers, to take a short-term view towards decisions about retraining and job or career

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

23 Special Senate Committee on Aging, *Final Report*, 1966. p. 27.

24 *Ibid*.

25 Peter Hicks, Human Resources and Social Development Canada, Evidence, December 4, 2006.

changes. The Committee has heard that, even in jurisdictions where mandatory retirement has ended, older workers still face the challenges of ageist employers who discriminate against those who are as young as 45 when it comes to hiring practices.[26] Several witnesses also told the Committee that seniors face significant financial disincentives to continue working. Some witnesses suggested the need for changes to programs such as the Guaranteed Income Supplement and the CPP/QPP, and called for an examination of the portability of pensions.

The Committee heard that such incremental change may not be sufficient, however, proposing further that "we should be looking at the whole system in a holistic and integrated perspective."[27] The adoption of a life-course approach as a policy framework will require both adjustments to current programs and a fundamental shift in how society recognizes and supports a wide variety of life-course choices, including the choice to work beyond the age of 65.

The Committee has heard that the health of seniors is intricately linked to experiences throughout their lives. Several witnesses reminded the Committee that aging is a life-long process and that health in the senior years hinges on supportive environments throughout life as well as during the senior phase of life. Inequalities throughout life lead to significantly different health outcomes in the senior years. For example, the Committee heard that understanding the social determinants of health was key to understanding the significant gaps in health and life expectancy between Aboriginal and non-Aboriginal Canadians. In its presentation, the National Aboriginal Health Organization noted that "Inuit, Métis, and First Nations communities continue to face critical housing shortages, high rates of unemployment, lack of access to basic health services, and low levels of education attainment, all of which affect both life expectancy and quality of life in senior years."[28] The Committee also heard that "the

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26 Judy Cutler, CARP – Canada's Association for the Fifty-Plus, Evidence, December 11, 2006.

27 *Ibid*.

28 Carole Lafontaine, National Aboriginal Health Organization, Evidence, November 27, 2006.

major risk factors for poor health are low income, especially for many single older women, low education and literacy, and social isolation."[29]

Given the above, the Committee will 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"[30]. Furthermore, the Committee will want to examine the determinants of health over the life-course which contribute to seniors' health or to situations of risk for seniors. Specifically, the Committee will want to examine the following questions:

- What are the public policy implications of moving toward an active aging/life-course approach to aging? Which programs at the federal level would be affected, and how? Have any countries moved towards adopting such an approach?
- What are the costs and benefits of a life-course approach to Canadian society and to diverse groups of seniors? Would there be financial costs or savings or would moving to such an approach be revenue-neutral?
- How might current programs and policies for those over 65, such as CPP/QPP, OAS and GIS, be affected in a move towards an active aging agenda? If there are changes to eligibility, how could these changes be managed in such a way as to minimize the negative impacts on people who are counting on the availability of these programs?
- What are the most critical determinants affecting the participation, health, well-being, and risks of seniors? Which health determinants are most influential in improving health and ensuring that seniors live full lives?

[29] Robert Dobie, National Advisory Council on Aging, Evidence, November 27, 2006.

[30] Jane Barratt, International Federation on Ageing, Evidence, December 11, 2006.

- How might programs and policies for those over age 65 be affected by intervening on these health determinants?[31]

1.4 Role of the Federal Government

> **"If governments are going to listen to this portion of the population, what better way than having a minister involved and dedicated strictly to seniors? This will have to become practice very soon. In the previous federal government, as in the current one, there were two or three ministers. It seems that everyone wants a piece of the pie, but there is no cohesiveness. If there is a ministry strictly for seniors, that will be very good for the senior population."[32]**

The responsibilities for programs and services for seniors rest at the federal, provincial/territorial, and municipal levels. Several departments are responsible for various issues and must work together at the federal/provincial/territorial level to address seniors' issues for all Canadians. At the federal level, although Human Resources and Social Development Canada has overall responsibility for seniors, several departments administer programs aimed directly at seniors. As one witness told the Committee, "Seniors and aging are broad horizontal issues and they are a fundamental part of the federal agenda."[33] The Committee heard from a number of witnesses who expressed a desire for a federal minister for seniors; however, the Committee was cautioned that such an approach has had varying results internationally, largely dependant on the mandate of the Minister. The Committee notes that a federal Secretary of State for

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31 These questions were identified in the following publication: Health Canada, *Toward Healthy-Aging Communities: A Population Health Approach. Report Prepared for the Division of Aging and Seniors*, by Linda MacLeod and Associates, 1997.

32 Robert Dobie, National Advisory Council on Aging, Evidence, November 27, 2006.

33 Margaret Gillis, Public Health Agency of Canada, Evidence, December 4, 2006.

Seniors was appointed in January 2007, and applauds the government for recognizing the importance of addressing the needs of the elderly.

The current multi-departmental, multi-jurisdictional responsibility for programs and services related to seniors can result in confusion for seniors attempting to gain information and access to services. Witnesses noted the challenges in providing seniors with easily accessible information on a wide variety of services. Witnesses also noted the difficulty in updating and coordinating one-stop information centres for seniors given the complexity of the system.

Given the above, the Committee will want to examine the role of the federal government in providing programs and services to our aging population. Specifically, the Committee will examine the following questions:

- Should there be a federal Minister for Seniors with a full mandate and with the resources to establish and direct a core basket of services?
- How does the Social Union Framework Agreement impact the potential role for the federal government in this area?
- Timely, accurate and accessible information on programs and services is essential. Does the federal government deliver information to seniors in ways which meet their diverse needs?
- Are national standards in areas such as home care and long-term care necessary? Are they compatible with the role of the federal government?
- Do Canadians expect the federal government to play a leadership role in developing programs which meet the needs of the senior population?

1.5 Next Steps

> **"Population aging is inevitable. Contrary to popular views, it is not reversible. It cannot be reversed; population aging is inevitable."[34]**

The mandate of the Committee is a very ambitious one. It is fair to say that the Committee terminated Phase One of its study with many more questions than answers. Each of the policy questions addressed above can open the door to significant inquiry and lead to recommendations on incremental changes which could benefit seniors. It is important to note that even though the Committee might choose to focus its Phase Two hearings along the four themes outlined above, nothing will prevent the Committee from making recommendations with a view to improving the well-being of senior Canadians in specific policy areas or concerning specific programs.

As it moves towards Phase Two of its work, the Committee is well placed to take a step back, consider alternatives to the traditional thinking about aging and seniors, and explore whether the aging of the baby-boom generation presents an opportunity for a paradigm shift in regards to seniors and aging. Whether a crisis or a challenge, the aging of the population deserves serious study.

[34] Byron Spencer, McMaster University, Evidence, November 27, 2006.

Part 2: Phase I Summary of Evidence

2. Understanding Canada's Aging Population

2.1 Demographics

Population aging refers to the increasing average age in a society and is characterized by the emergence of a greater proportion of older persons in the overall population. Demographic changes – including population aging – are determined by the domestic fertility (birth) rate, domestic mortality (death) rate, and the nature and rate of immigration.

Beginning in the late 19th century and continuing throughout most of the 20th century, life expectancy in developed countries has generally increased continuously while fertility rates have declined. With the exception of increased fertility rates during the post-World War II baby boom, these trends have been reflected in Canada's population growth and demography. "A level of 2.1 children is required to ensure population replacement, a level that has not been experienced in Canada since 1971."[35] While the fertility rate of Aboriginal Canadians is considerably higher than non-Aboriginals, "they account for only 3 per cent of the total population and contribute to about 7 per cent of the overall natural demographic population increase."[36]

Statistics Canada's most recent population projections indicate that Canada's population will continue to grow, but the rate of growth will decrease over time. The population of Canada is projected to increase from 32.3 million in 2005 to approximately 39 million in 2031, and 42.5 million in 2056.[37] "Canada's rate of natural increase is projected

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35 Pamela White, Statistics Canada, Evidence, November 27, 2006.

36 *Ibid*.

37 The most recent study, *Population Projections for Canada, Provinces and Territories, 2005-2031*, was published in 2005 and provides population projections for Canada for 2006-2056. Unless otherwise stated, all figures are for the medium-growth scenario, which generally assumes the

to become negative between 2025 and 2030 if the country's level of fertility remains at its current low level of 1.5 children per woman,"[38] after which immigration will sustain declining levels of population growth. International migration is already Canada's main source of population increase: "Since 2000, over two thirds of population growth has been due to international migration."[39] Although it is at historic lows, Canada's population growth rate "remains significantly higher than Japan or Western Europe."[40] In fact, the Committee has heard that "by international standards Canada has a much lesser concern with population aging than most already prosperous countries."[41]

The declining fertility rate and increased life expectancy are also leading to an increasing proportion of elderly among the Canadian population.

> **"The proportion of persons age 65 or over was 8 per cent in 1971. It is 13 per cent today. When the first cohort of baby boomers reaches the age of 65 or over in 2011, another significant change will occur as the proportion of elderly among the total Canadian population will begin to increase more rapidly. It is projected that by 2031, about one in four Canadians will be 65 years of age or over. Canada's population is aging fast. … The proportion of oldest seniors, those 80 years or over, would also increase sharply. By 2056, an estimated 1 out of 10 Canadians will be 80 years or over, compared with about 1 in 30 today."[42]**

One of the implications of an increase in the proportion of elderly among the population is a rise in the dependency ratio, which is defined as the proportion of children (aged 0-14 years) and elderly

continuation of current demographic trends (e.g., birth rates, life expectancy and immigration).

38 Pamela White, Statistics Canada, Evidence, November 27, 2006.

39 *Ibid*.

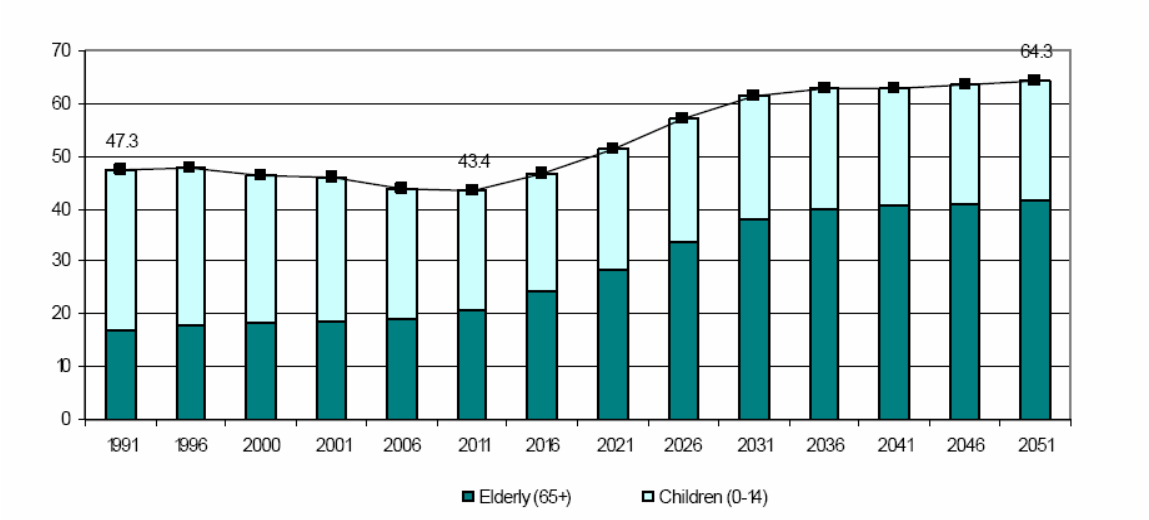
40 *Ibid*.

41 Byron Spencer, McMaster University, Evidence, November 27, 2006.

42 Pamela White, Statistics Canada, Evidence, November 27, 2006.

(aged 65 years and older) relative to the total working-age population (aged 15-64 years). As Figure 2-1 indicates, the dependency ratio is expected to increase significantly between 2011 and 2051, as the first baby boomers reach retirement age and as the smaller cohorts born after the baby boom generation reach their prime working years. The composition of "dependents" is also expected to change: "Regardless of the projection scenario, by 2015 seniors aged 65 or over will become more numerous than children under 15. This would be an unprecedented situation in Canada."[43]

Figure 2-1: Dependency Ratio in Canada, 1991-2051



Source: Statistics Canada, Population Projections for Canada, Provinces and Territories, 2000-2026, March 2001, Table 21, p. 77.[44]

The overall national trends of an aging population mask significant differences across population subgroups and regions. Witnesses reminded the Committee that, "Seniors are not a monolithic group of poor, frail, sick or dependent persons. The 65-plus group presents considerable diversity in terms of life experiences, economic status, health status and resources for independent living."[45] A striking

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43 *Ibid*.

44 The dependency ratio expresses the number of people of "dependent age" per 100 persons of "working age." Beginning in 2001, all figures are projections.

45 Robert Dobie, National Advisory Council on Aging, Evidence, November 27, 2006.

example is the difference in life expectancy at birth among Registered Indians, Inuit-inhabited regions and the overall Canadian population:

Figure 2-2: Life Expectancy (years) for Canada (2001), Registered Indians (2001) and Inuit-inhabited regions (1999-2002)

	Canada	Registered Indians	Inuit Regions
Males	77	70	65
Females	81	76	70

Source: Health Canada, First Nations and Inuit Health Branch Fact Sheet, November 16, 2006

Like the broader Canadian population, the growing segment of the elderly population represents tremendous diversity in terms of age, gender, ethnocultural background, regional differences and in the settings – urban or rural – in which they live. Witnesses also pointed out that the aging of the population does not occur evenly across Canada, in part due to migration within the country. The regional imbalance in aging has important implications for labour market planning and the distribution of aging-related costs.

2.2 Young-Old, Middle-Old and Frail-Old

With recent gains in life expectancy, an increasing number of Canadians are living longer and are in better physical and mental health. "A male 65 today has [a] life expectancy of almost 18 more years; a female 65 today has a life expectancy of 21 more years."[46] Witnesses have pointed out the importance of recognizing the differences between different age groups of seniors:

> **"The difference between a 65-year-old and a 90-year-old is 25 years. There is a difference between someone who is 25 and someone who is 50. Why put those two people together in the same category? Their needs are very different, and we need to think differently about those groups."[47]**

[46] *Ibid*.

[47] Douglas Durst, University of Regina, Evidence, November 27, 2006.

Douglas Durst also noted that literature on seniors often refers to the need to distinguish three broad age categories:

> **"First, are those from 65-75 years -- the young old -- who are healthy, fit and reasonably affluent. They want to travel and do things and are still in a creative and productive period of their lives. Second, are those from 75-85 years of age -- the middle old -- who are starting to slow down and are more interested in tending to their gardens and spending time with grandchildren. They have some money and resources but are beginning to watch how they spend and they are less interested in travel and making major purchases. Third, are those 85 years of age and over into their 90s -- the frail old -- who have special social and physical needs."[48]**

2.3 Gender Inequality

Through the 1980s and 1990s, the rate of low income among Canada's seniors declined appreciably (see section 6 for a more detailed discussion of income security). Despite these improvements, a significant gap remains between female and male seniors. Whether they are in one-person households or primary earners in two-person households, senior women are more likely to experience low-income status than their male counterparts.

The National Advisory Committee on Aging identified senior women, especially unattached senior women, as being at particular risk. Older women tend to have lower incomes due to a combination of lower participation rates in the paid labour force, and lower wages in paid employment. In 2005, about one in five senior women had never worked outside of the home. Because women live longer, they are also at greater risk of running out of savings over their lifetime.[49]

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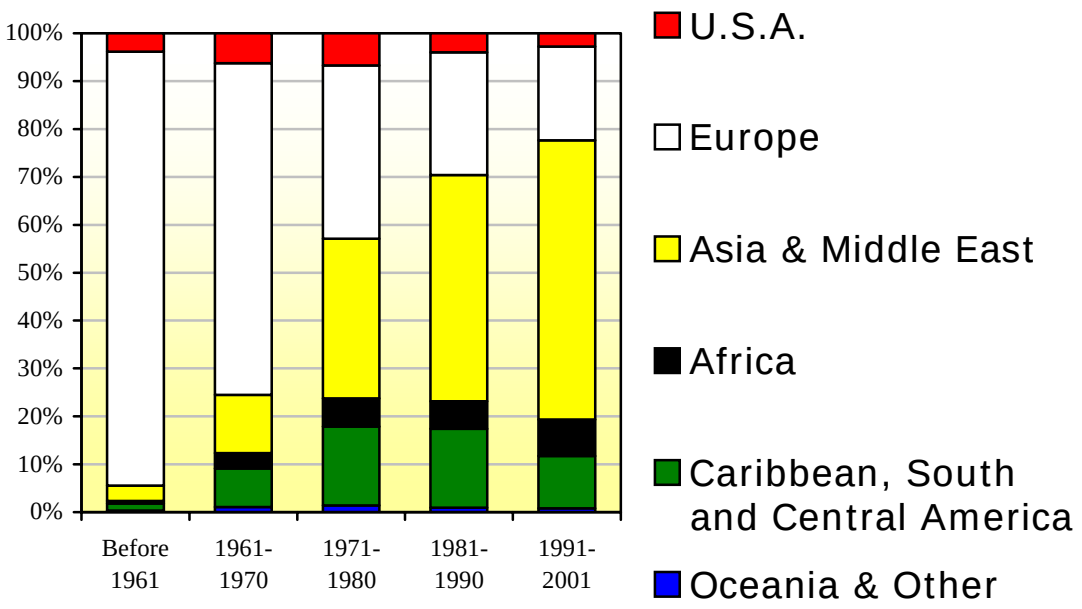
48 *Ibid*.

49 National Advisory Council on Aging, *Seniors in Canada 2006 Report Card*, 2006.

2.4 Multicultural Diversity

The increasing importance of immigration to Canada's population growth is a significant factor that is already influencing the composition of the senior population. The graph below illustrates the shifts in the countries of origin of immigrants to Canada through the second half of the 20th century.

Figure 2-3: Origin of Immigrants to Canada, 1961-2001[50]



This trend is generating rapid changes in Canada's population: between 1996 and 2001, the total population grew by 4%, while the visible minority population rose by 25%. The impacts are already being seen in Canada's senior population.

> **"In the past 25 years, there has been a dramatic change in the senior population among immigrants. Of all seniors… close to 20 per cent, are from Europe. However, the immigrant patterns from Asia show that 5.4 per cent, or 1 in 20 seniors in Canada, are Asian. Overall, 7.2 per cent of Canada's senior**

[50] Brief submitted by Pamela White, Statistics Canada, November 27, 2006, p. 7.

> **population are a visible minority. That is a significant increase in the past ten years."[51]**

The immigrant population is also older on average than the Canadian population as a whole. "Almost 19 per cent of the immigrant population in Canada is over 65, and this number is much higher than the national average of 12.2 per cent."[52]

2.5 Regional Differences Across Canada

Witnesses confirmed that the effects of population aging are not felt equally across Canada. "With few exceptions, the older population in Canada is found east of Ontario, with the population resident west of Quebec and in the territories being younger."[53] The gap in median age between the Eastern and Western provinces is expected to increase as the population ages, as illustrated below by differences in population growth and the proportion of seniors in the overall population presented to the Committee by Byron Spencer. "Atlantic Canada and Quebec will experience a more rapid aging of the population compared with Ontario, the Western provinces and territories."[54]

2.6 Urban / Rural Considerations

Witnesses confirmed that urban areas have a median age which tends to be lower than rural areas. Pamela White of Statistics Canada told the Committee that, "Overall, the median age of those living in Canada's metropolitan centres is lower, 37.7 years, compared to those living elsewhere, 40.7 years."[55]

Urban and rural areas face different challenges in supporting senior populations. In rural regions, youth out-migration, low levels of immigrant in-migration, low birthrates and growing tendency for some to seek retirement in rural areas contribute to a decreasing and aging

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51 Douglas Durst, University of Regina, Evidence, November 27, 2006.

52 *Ibid*.

53 Pamela White, Statistics Canada, Evidence, November 27, 2006.

54 *Ibid*.

55 *Ibid*.

population. Although one-third of Canadian seniors live in rural areas, decreasing populations pose challenges to maintaining services there.

> **"The rural-urban move … exaggerates the effects associated with population aging in the departing areas, the smaller communities and rural areas. … In many smaller areas in the Atlantic region you are left with very old populations indeed. The median age can be 60 and even quite a bit older than that in some of the small areas. There are huge problems not just with health delivery, but also with education, because you end up with very small groups in school."[56]**

The Committee heard evidence that seniors in remote communities often have to travel to urban areas to access long-term care. But while urban centres can provide the specialized services required, the co-ordination of support services and continuing care is often inadequate. These issues are magnified for Aboriginal seniors, who experience cultural alienation within urban environments:

> **"The urban areas are unable to provide the social aspect [of care]. Just the question of meals is a very big problem. That was pointed out by the representatives of the Aboriginal people that we have met; the question of meals and cultural differences. It is enough to drive them sick again."[57]**

The Public Health Agency of Canada noted that four Canadian sites – Portage la Prairie, Manitoba; Saanich, British Columbia; Sherbrooke, Quebec; and Halifax, Nova Scotia – are among 34 cities around the world participating in an initiative to foster the development of age-friendly cities that promote active aging and focus on seniors. A parallel project is being developed by the Public Health Agency of Canada and Human Resources and Social Development Canada

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56 Byron Spencer, McMaster University, Evidence, November 27, 2006.

57 Robert Dobie, National Advisory Council on Aging, Evidence, November 27, 2006.

through the Ministers responsible for seniors to explore age-friendly factors in small, rural and remote Canadian communities.[58]

2.7 Gaps in Information

Witnesses noted that a number of population subgroups and areas of inquiry warrant further investigation, notably Aboriginal seniors, immigrant seniors, and seniors with intellectual and developmental disabilities.

For example, although the health outcomes for Aboriginal peoples are known to be worse than the Canadian population as a whole, the National Aboriginal Health Organization highlighted a need for more information on Aboriginal seniors:

> **"There is a serious lack of information on First Nations, Inuit and Métis health across the board, especially with regard to older Aboriginal people. The focus is on the younger generation, because there are so many young Aboriginal people."[59]**

Douglas Durst further cautioned the Committee that,

> **"There is the danger of applying models and aggregating data from different groups as a form of reductionism, which invites generalizations and assumptions that may be false or misleading."[60]**

Like the broader Canadian population, the senior population is undergoing a number of dynamic shifts, which means that planning must be based on its anticipated characteristics in the future.

> **"Regarding core services, … our older adults are changing. We know that primarily older adults are females -- that is quite evident. There are financial**

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58 Margaret Gillis, Public Health Agency of Canada, Evidence, December 4, 2006.

59 Mark Buell, National Aboriginal Health Organization, Evidence, November 27, 2006.

60 Douglas Durst, University of Regina, Evidence, November 27, 2006.

changes they experience and education changes. We are planning for senior population now and in 10 years it is a different population."[61]

2.8 Questions for Further Study

The demographic information provided to the Committee point to a number of questions for further study. In addition, the demographic profile of the aging population gives rise to a number of considerations the Committee will incorporate into the process of developing recommendations in the second phase of its study.

Specific questions

- Will the regional disparities in aging exacerbate existing differences in the baskets of services that are currently available in the different provinces and territories? Are federal/provincial/territorial financing arrangements responsive to the regional imbalances in the aging population?
- Senior women experience higher levels of poverty than their male counterparts. Is this gap expected to close among future cohorts of seniors women, who have greater labour force attachment? If not, why?
- What kinds of services will immigrant communities require as their senior populations age? In which ways are these needs similar or different from those of the general population?

Demographic Considerations in the Development of Recommendations

- The Committee takes note of the following policy questions (identified by the Federal/Provincial/Territorial Ministers Responsible for Seniors[62] in their National Framework on Aging in 1998) to help it evaluate policy options as it embarks on the second phase of its study:

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61 Sandra Hirst, Canadian Association on Gerontology, Evidence, December 11, 2006.

62 With the exception of Québec.

- Does the policy/program address the diverse needs, circumstances, and aspirations of various sub-groups within the seniors population (e.g., age, gender, family status, geographic location, Aboriginal status, official language minorities and ethnocultural minorities, income status, health status, etc.)?
- Does the policy/program reflect and respond to the different realities between genders?
- Does it adequately consider the diversity among various age segments of older Canadians (e.g., those who lived through the Great Depression, wars, linguistic or cultural differences, etc.)?

3. Seniors at Risk

In its presentation to the Committee, the National Advisory Council on Aging identified groups of seniors who face particular challenges. "Right now, the economic well-being of some seniors continues to be at risk [...] Certain groups, among them older women, unattached seniors and immigrant seniors are at particular risk."[63] In this section, we will also look at some other issues of importance to seniors, such as emergency preparedness, and abuse and neglect.

3.1 Immigrant Seniors

The previous section provided some information on the increasing ethnocultural diversity of Canada's population, including seniors. In general, however, the Committee has heard that aging-related programs and policies continue to treat the senior population as a homogenous group, often not recognizing the range of needs, concerns and histories of ethnocultural minority seniors.[64] There can be important barriers to gaining access to health care and other services that result from language and culture differences, low income, discrimination and racism.

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63 Robert Dobie, National Advisory Council on Aging, Evidence, November 27, 2006.

64 National Advisory Council on Aging, *Seniors on the Margins: Seniors from Ethnocultural Minorities*, 2005.

Although seniors' economic well-being improved overall in the last decades of the 20th century, a gap remains between immigrant and non-immigrant seniors.

> **"In 1995, older immigrant men received 8.5% less income than Canadian-born men, while older immigrant women received 9.2% less income than Canadian-born women. Immigrant seniors, especially women, face higher rates of poverty than seniors born in Canada. In 1995, 17.5% of immigrant senior men and 26.5% of immigrant senior women had low incomes compared to 11.5% of non-immigrant senior men and 23% of non-immigrant senior women."[65]**

Economic insecurity is most severe for immigrant seniors who have been in Canada for less than 10 years. In fact, the older the age at immigration, the more likely one will live in poverty,[66] since one's chances of being able to access public income support programs for seniors depend on length of residency in the country.

Culturally-specific belief patterns about illness and health, attitudes about dependency and self-sufficiency, as well as language barriers can impede or reduce access to health and long-term care, family support and community services. The Committee heard evidence about the difficulty that some care institutions can have in adapting to the different needs, illnesses and disabilities of immigrant seniors.

3.2 Aboriginal Seniors

The Aboriginal population is younger than the non-Aboriginal population in Canada. Almost half of Aboriginal Canadians are under age 20, while just under 6 per cent are over 65.[67] In comparison, 22% of the total Canadian population was under 20 in 2006, and 13%

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65 *Ibid*.

66 Kazemipur, A. and S. S. Halli. "Poverty Experiences of Immigrants: Some Reflections." *Canadian Issues*, April 2003.

67 Leslie MacLean, Health Canada, First Nations and Inuit Health Branch, Evidence, December 4, 2006.

over 65.[68] But a dramatic increase in the number of Aboriginal seniors is expected.

> **"Current statistical data projects that by 2026, the percentage of Aboriginal seniors will triple. While we must strive for optimal conditions for the general senior population in Canada, the vulnerable health of Aboriginal seniors requires specific attention, with interventions that are culturally appropriate."[69]**

Health outcomes for Aboriginal persons tend to be worse than for non-Aboriginal persons in Canada, and seniors are no exception. Among First Nations and Inuit, chronic diseases usually associated with older age such as diabetes, rheumatoid arthritis or cardiac conditions, are more prevalent than they are in the general population and have an earlier onset.[70]

Compounding the challenge of worse health outcomes are the conditions in which many Aboriginal people live as well as more complicated access to health care and support services. Douglas Durst described the situation of some First Nations seniors in Saskatchewan:

> **"More seniors tend to stay on the reserve in the population. They tend to be in housing that is overcrowded, substandard, with poor water, and at a certain age almost all of them have diabetes, type 2. … They are with their families, and as disabilities increase they get further socially isolated there. Then when they come to Regina they are in very poor health and physical condition and have a great demand on services. There does not seem to be a very strong infrastructure for supports for home care and supporting the family in caring for them."[71]**

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68 Statistics Canada, Population Projections for Canada, Provinces and Territories 2005-2031, Catalogue no. 91-520-XIE, 2006.

69 Carole Lafontaine, National Aboriginal Health Organization, Evidence, November 27, 2006.

70 Leslie MacLean, Health Canada, First Nations and Inuit Health Branch, Evidence, December 4, 2006.

71 Douglas Durst, University of Regina, Evidence, November 27, 2006.

The small size and remote locations of many First Nations and Inuit communities mean that many formalized medical services require travel. A preference for family care and a reluctance to leave home for treatment mean that many health problems have worsened and created additional complications by the time health professionals are consulted.

Aboriginal seniors in urban areas who have access to health care services do better in terms of overall health, but tend not to access available programs and services, leaving them isolated. The Committee heard that some Aboriginal people in urban areas "do not feel comfortable going to white-dominated agencies."[72] Many get caught and "kicked around" between federal, provincial, and band jurisdictions, complicating access to programs and services.

Given the significant differences in health and life expectancy, the Committee heard that the age of eligibility for seniors' programs and services, commonly set at 65, may not be appropriate for Aboriginal people. In his presentation to the Committee, Douglas Durst referred to recent US research that recommended using "55 as being equivalent to 65" when working with Aboriginal populations, and that "we ought to be looking at providing services and programs for a younger chronologically aged group for seniors due to the health and social conditions, diabetes, and so on."[73]

The current health status of Aboriginal populations and the projected growth in the senior population point to the need for immediate action. The National Aboriginal Health Organization called for "long-term investment in the health of individuals throughout their lifespan and investments in community infrastructure to meet those demands in the next 10 to 25 years."[74]

The National Aboriginal Health Organization also advised the Committee that a pan-Aboriginal approach is not effective when addressing the issues facing Aboriginal seniors. "First Nations, Inuit

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72 *Ibid*.

73 *Ibid*.

74 Carole Lafontaine, National Aboriginal Health Organization, Evidence, November 27, 2006.

and Métis have contextually specific realities that are influenced by such determinants as language, geography, and culture… Policy construction and program delivery must be informed by specific data that captures the need according to First Nations, Inuit and Métis realities."[75]

3.3 Unattached Seniors

Between 1991 and 2001, the number of seniors living alone increased, especially among seniors over 85. More than 1 million seniors were living alone in 2001; almost three quarters of them were women. The National Advisory Council on Aging emphasizes how "learning to live alone later in life following the loss of a spouse can be very challenging psychologically and financially."[76]

Single-person households have consistently higher rates of low income than other households among all ages of the Canadian population, including seniors. According to Statistics Canada, unattached seniors had a low-income rate of 15.5 per cent in 2004, compared to 5.6 per cent for all seniors.[77]

Figure 3-1: Percentage of Seniors with Low After-Tax Income

	Both sexes	Men	Women
All seniors	5.6%	3.5%	7.3%
Families of Seniors	1.6%	1.7%	1.6%
Unattached seniors	15.5%	11.6%	17.0%

Source: Statistics Canada, Income in Canada 2004

Seniors living alone are at higher risk of housing affordability problems, health problems, and social isolation. They are also less likely to be happy compared to seniors living with a spouse or children,

75 *Ibid*.

76 National Advisory Council on Aging, *Seniors in Canada 2006 Report Card*, 2006.

77 Statistics Canada, *Income in Canada 2004*, Catalogue no. 75-202-XIE, 2006.

in part because they spend more time alone and in part because of low income.[78]

3.4 Abuse and Neglect

Senior abuse can be perpetrated in the home or within institutions, and includes psychological, physical and financial abuse, and neglect. The 1999 General Social Survey on Victimization found that 7% of adults 65 years and older reported some form of emotional or financial abuse by an adult child, spouse or caregiver in the five years prior to the survey, with the vast majority committed by spouses. A smaller proportion (1%) reported experiencing physical or sexual abuse.[79] These reported rates may be lower than actual incidences of abuse, however, as victims can be unwilling or unable to report abuse for a variety of reasons including cognitive impairments, dependence on the abuser, linguistic or cultural barriers, fear of retaliation and shame or stigma.

As with the general population, most abuse carried out against seniors is perpetrated by someone known to the victim. In the case of seniors, it is often a family member, friend, caregiver, landlord or staff in a facility.[80] Seniors who are at greater risk of abuse include older seniors, women, socially isolated seniors, dependent seniors with disabilities, seniors with reduced cognitive capacity, and seniors whose caregivers have a drug or alcohol problem.[81]

Although only 7% of older Canadians live in institutions, institutional abuse is also a concern. It can take many forms, including inappropriate or lack of staff-client interaction, low standards of nursing care, theft and fraud, inadequate nutrition, overcrowded floors, lack of privacy, and issues of cleanliness.[82] The Committee

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78 National Advisory Council on Aging, *Seniors in Canada 2006 Report Card*, 2006.

79 Justice Canada, *Abuse of Older Adults: A fact sheet from the Department of Justice Canada*, www.justice.gc.ca/en/ps/fm/adultsfs.html

80 National Advisory Council on Aging, "Hidden Harm, the Abuse of Seniors" in *Expression*, Vol. 17, No. 1, Winter 2003-2004.

81 *Ibid*.

82 National Advisory Council on Aging, *Seniors in Canada 2006 Report Card*, 2006, p. 45.

heard about how long-term care facilities face new challenges. "The care is more complex and people have not been trained in complex care. That is a new area developing before our eyes."[83] Witnesses suggested that this environment could contribute to staff burnout, decreased quality of care, neglect and abuse.

The Government of Ontario has introduced legislation that would establish a new system of governance for long-term care homes and strengthen enforcement in an effort to improve care and accountability. Lynn McDonald cited Ontario's Bill 140 as a widely acclaimed model for the way in which it sets standards and proposes a protocol to be followed when abuse occurs in the care of seniors.[84]

3.5 Emergency Preparedness

Recent international crises such as the SARS outbreak in Toronto, the 2003 heat wave in France, and Hurricane Katrina have demonstrated how seniors can be at particular risk during emergencies or disasters and why emergency planning that takes into account the needs of seniors is so important.

Research shows that people over 60 are far more likely to be hurt or killed in a disaster.[85] Seniors with physical disabilities or conditions that affect mobility or agility may not be able to quickly evacuate or may miss emergency instructions. Seniors that depend on family or community supports may be left stranded if transportation and communication systems break down. Seniors with low incomes and those dependent on income supports are also at risk as these supports may be temporarily unavailable.[86]

To help determine the best approaches to ensure that older adults are considered in all aspects of planning, responding and recovering

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83 Lynn McDonald, National Initiative for the Care of the Elderly, Evidence, December 11, 2006.

84 *Ibid*.

85 National Advisory Council on Aging, "When Disaster Strikes!" in *Expression*, Vol. 19, No. 3, Summer 2006.

86 Public Health Agency of Canada, "Seniors During Emergencies and Disasters: Vulnerable, Yet Resilient" Canadian Health Network.

from emergencies, the Public Health Agency of Canada is hosting an international workshop on emergency preparedness and seniors in Winnipeg in February 2007, "with 100 world experts and seniors, to develop a blueprint for action and to influence changes to emergency preparedness policy and practice in order to better integrate seniors' contributions and needs."[87]

3.6 Questions for Further Study

- To what extent are the federal government's policies and programs tailored to the needs of immigrant seniors?
- Is the federal government taking a pan-Aboriginal approach in working with Aboriginal seniors?
- Is age 65 used as an eligibility requirement for Aboriginal seniors to access programs? Given the poor health of Aboriginal populations, can alternative measures be used?
- Are there models of successful coordination of services across multiple jurisdictions that could be helpful in the delivery of federal, provincial and band services to Aboriginal seniors?
- What can be done to improve the low-income rate and other risk factors for unattached seniors?
- What can the federal government do to prevent senior abuse?

4. Active Participation in Society and Economic Life

The World Health Organization has adopted the term *active aging to* describe the process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age.[88] Promoting active aging involves understanding what different groups of seniors want and facilitating the roles they choose to play in paid employment, volunteering, caregiving, and leisure.

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87 Margaret Gillis, Public Health Agency of Canada, Evidence, December 4, 2006.

88 United Nations – World Health Organization, *Active Ageing: A Policy Framework*, 2002.

4.1 Promoting Active Living, Well Being and Participation

The Committee heard that Canadians are living longer, and that those additional years are spent, for the most part, in good health. One of the keys to maintaining health and quality of life over a lengthening lifespan is to sustain the ability to participate in meaningful activities and social networks.

> **"One of the current most accepted views is that 'aging well' is about finding meaning and purpose in the activities in which one engages. Engagement in activities which are personally meaningful and freely chosen has been found to be related to positive physical and psychological outcomes."[89]**

While healthy seniors continue to be active and involved in their families and communities, the way they use their time is shifting. Statistics Canada found that in 2005, more Canadians 55 to 74 years old were engaged in the labour force, working later in life and spending less time in leisure activities compared to 1992 and 1998.[90]

> **"Having paid work beyond the normal retirement age (as long as it is done voluntarily rather than because of financial hardship) seems to improve quality of life, as does volunteering and being involved with grandchildren. What all these activities have in common is that they all help to maintain a person's involvement with a social network of workmates, friends and family. … [S]ocial support of this kind helps older people to maintain their quality of life if they develop an illness."[91]**

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89 Statistics Canada, "Aging Well: Time Use Patterns of Older Canadians", General Social Survey on Time Use: Cycle 19, 2005, Catalogue no. 89-622-XIE.

90 Statistics Canada, Aging Well: Time Use Patterns of Older Canadians 2005, p. 24.

91 Bartley, Mel (ed.) *Capability and Resilience: Beating the Odds*, University College of London Department of Epidemiology and Public Health and the

Pamela White also told the Committee that the burden of ill health on seniors remains important:

> **"As their number of years of good health has increased at the same pace as … life expectancy, the burden that ill health represents over the life cycle has remained about the same over the past 10 years."[92]**

Statistics Canada has found a strong link between health status, active living, life satisfaction and time use of older Canadians.

> **"Health status has a significant influence on time spent on a range of activities. Healthy individuals spent more on paid work, unpaid work and active leisure. Generally, the fit or balance of activities for healthy, satisfied women included less time on paid work for working age women than their healthy, less satisfied counterparts and more time on active leisure like cognitive and physical activities. For healthy, satisfied men there was no consistent set of activities across the age groups. Less healthy and less satisfied men and women for all age groups consistently spent the most time on passive leisure."[93]**

Technical aids such as communication devices, visual and hearing aids, prosthetic and orthotic devices, wheelchairs and walking aids can also help seniors continue to participate in society. Unfortunately, accessing these supports can be complicated and costly, involving diverse departments at all levels of government, and creating expenses that are not covered by any public or private plan for an estimated 36 per cent of adults.[94]

Economic and Social Research Council Priority Network on Capability and Resilience, 2006.

92 Pamela White, Statistics Canada, Evidence, November 27, 2006.

93 Statistics Canada, Aging Well: Time Use Patterns of Older Canadians 2005, p. 24.

94 Caledon Institute of Social Policy, *Preparing for the Demographic Tsunami,* July 2006.

4.2 Financial Security and Retirement

One of the most significant areas of government intervention related to seniors is income support. A combination of policies and programs has significantly reduced the number of seniors living in poverty since the beginning of the 1980s, with the number reaching 5.6 per cent in 2004. This is down from 6.8 per cent in 2003 and 21 per cent in 1980, and is the lowest rate of seniors in low income for the 25-year period 1980 to 2004 for which Statistics Canada has estimates. Peter Hicks noted that Canada's rate has gone from "…one of the worst in the OECD to one of the best, close to the best, in that time frame."[95]

The incidence of low income among seniors (5.6 per cent in 2004) is lower than the overall rate for the Canadian population (11.2 per cent), but as mentioned previously, some groups of seniors, such as unattached seniors, are more likely to experience poverty. Single seniors have a low-income rate 10 times that of seniors living in families: 16 per cent compared to 1.6 per cent. Single senior women are almost twice as likely to be in low income as men, with a low-income rate of 17 per cent, though this has fallen over two decades from 57 per cent in 1980. The rate for senior men has decreased from 47 per cent in 1980 to 12 per cent in 2004.[96]

While low income rates overall have improved for seniors, inequalities in retirement income have started to rise and are expected to continue to do so. As Robert Dobie pointed out: "It is becoming clear that inequalities in retirement income will increase in the future."[97]

The main sources of income for seniors are government transfer payments, private retirement plans, employment earnings and the wealth they have accumulated in their lifetime.[98]

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95 Peter Hicks, Human Resources and Social Development Canada, Evidence, December 4, 2006.

96 Statistics Canada, *Income in Canada 2004*, March 2006, p. 16.

97 Robert Dobie, National Advisory Council on Aging, Evidence, November 27, 2006.

98 National Advisory Council on Aging, *1999 and Beyond, Challenges of an Aging Canadian Society*, Ottawa, 1999, p. 53.

In 2004, 99 per cent of all seniors, both single and in families, received some income in the form of government transfers. These transfers came largely from the Canada Pension Plan, the Quebec Pension Plan, Old Age Security, and the Guaranteed Income Supplement. Despite the fact that the median level of government transfers to seniors has remained relatively constant over the last decade, government transfers remain an important portion of seniors' incomes – in 2004, senior families received almost six times as much of their total income from government transfers as non-senior families. For every $100 of pre-tax income in 2004, senior families received $41 from government transfers, compared to just over $7 for non-senior families. Of the remaining $59 in income for senior families, $34 came from private pensions (up from $27 in 1996), $12 from earnings, $10 from investment income, and the rest from other sources.[99]

Employment and Retirement

The new demographic reality of the aging workforce and potential labour shortages has made way for discussions of alternative approaches to the work-life cycle. Although the majority of seniors retire at 65, there still exists a percentage that chooses to continue to work. In fact, "about one-third of those who retired between 1992 and 2002 were healthy individuals who would have been willing to continue working if circumstances had been different."[100] The percentage of working seniors increased from 6 per cent in 2001 to 8 per cent in 2005.[101] Many seniors also return to paid work following an initial retirement, mostly on a part-time basis.[102] The growth in employment among seniors aged 65 to 69 – the fastest rising employment age group in 2004 – contributed to a 30 per cent increase

99 Statistics Canada, *Income in Canada 2004*, Catalogue no. 75-202-XIE, 2006.

100 René Morissette, Grant Schellenberg and Cyntia Silver, "Retaining older workers" in *Perspectives on Labour and Income*, vol. 5, No. 10, Catalogue No. 75-001-XIE, Statistics Canada, October 2004, p. 3.

101 National Advisory Council on Aging, *Seniors in Canada 2006 Report Card*, p. 52.

102 Health Canada, *Canada's Aging Population*, Ottawa, 2002, p. 15.

in the market income of the average senior family between 1996 and 2004.[103]

Mandatory retirement has been banned in Alberta, Manitoba, Ontario, Québec, Prince Edward Island, Nunavut, the Yukon and the Northwest Territories. Ontario's legislation came into effect in December 2006. In November, Saskatchewan introduced a bill to end mandatory retirement, and B.C. Premier Gordon Campbell has said that his government would address the issue during the Spring 2007 sitting of the legislature.[104] The number of seniors indicating that they were forced into retirement because of mandatory retirement policies fell from 16.2 per cent in 1994 to 14.5 per cent in 2002.[105] The Canadian Association for the Fifty-Plus indicated that mandatory retirement has had a negative impact on the lives of many Canadians noting, for example, that "…we hear from many for whom mandatory retirement means poverty, social isolation and the loss of meaningful activity, all of which can lead to physical and mental illnesses, thereby putting unnecessary stress on the health care system. The alternative contributes to independence and quality of life."[106]

In provinces where mandatory retirement has been eliminated, the Committee heard that forms of age-based discrimination remain. "[E]ven where mandatory retirement has ended older workers still face the challenges of ageist employers who discriminate against those who are as young as 45 when it comes to hiring practices."[107] Human Resources and Social Development Canada described a recent government investment of, "$70 million for a national cost-shared program with the provinces and territories called the Targeted

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103 Statistics Canada, *Income in Canada 2004*, Catalogue no. 75-202-XIE, 2006.

104 Cynthia Ross Cravit, "B.C., Saskatchewan to end mandatory retirement", part of CARP News Articles, CARP – Canada's Association of the Fifty Plus, www.carp.ca, January 17, 2007.

105 National Advisory Council on Aging, *Seniors in Canada 2006 Report Card*, p. 52.

106 Judy Cutler, CARP – Canada's Association for the Fifty Plus, Evidence, December 11, 2006.

107 *Ibid*.

Initiative for Older Workers"[108] that is designed to help unemployed older workers remain active and productive participants in the labour market while their communities undergo adjustment.

Both CARP – Canada's Association for the Fifty-Plus and the International Federation on Ageing suggested that there is a need for a comprehensive review of pension reform to remove disincentives for continued employment for those seniors who would like to remain employed. They cautioned, however, that any proposed reforms should be carefully considered to ensure that they would not create situations where seniors would be obliged to continue working when they would prefer retirement (i.e. by delaying the age of pension eligibility), or reduce benefits for workers who have planned for retirement based on current arrangements. The International Federation on Ageing noted that many other developed countries have undertaken pension reform to deal with this issue.

Canada Pension Plan and Private Pensions

Established in 1966, the Canada Pension Plan (CPP) provides over 3 million retired Canadians with maximum benefits of up to $844 per month. Federal and provincial Ministers of Finance, as joint stewards of the CPP, completed a triennial financial review in June 2006[109] and the Committee heard that the CPP is on "sound financial footing for at least the next 75 years and that includes the peak of the aging population."[110]

Because benefits are tied to employment earnings, a gender gap still exists in benefit coverage. In 2002, only 83.8% of female tax filers 65 or older reported income from the C/QPP, compared to 94.5%

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108 Peter Hicks, Human Resources and Social Development Canada, Evidence, December 4, 2006.

109 Department of Finance Canada, "Review Finds Canada Pension Plan is Financially Sound," 27 June 2006, www.fin.gc.ca/cpp/news/20060627_e.html

110 Peter Hicks, Human Resources and Social Development Canada, Evidence, December 4, 2006.

for men.[111] Unpaid work most often done by women, including child and elder care, interrupt or reduce paid work and diminish women's ability to accumulate pension benefits and retirement savings.

The Committee heard from numerous witnesses that disincentives to postponing retirement must be reduced. One of those disincentives is the CPP benefit structure:

> **"You can elect to receive retirement benefits under the Canada Pension Plan as young as age 60, or you can defer them to age 70, the normal age being defined as 65. If you take the benefits younger than age 65, you get a reduced benefit, and the reduction is roughly in keeping with life expectancy on average. If you opt to take them at an older age, you get an increased benefit, but it does not increase as much as the loss in life expectancy after age 65. From a policy point of view, there is clearly some incentive built into the Canada Pension Plan not to defer benefits until after age 65 but rather to take them then."[112]**

As retirement income levels increase, private pension plans represent a growing share of seniors' incomes.[113] However, less than 50 per cent of seniors benefit from a private pension plan.[114] The Committee heard that, "Less than a third of Canadians who are not employed in the public service … have private pension plan coverage."[115]

Compounding the inadequacy of low levels of private pension coverage is that in many cases the pension investments are not portable: "[E]ven among those who do have some coverage, many

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111 Ken Battle, *Sustaining Public Pensions in Canada: A Tale of Two Reforms*, Ottawa, Caledon Institute of Social Policy, 2003, www.caledoninst.org/PDF/553820622.pdf

112 Byron Spencer, McMaster University, Evidence, November 27, 2006.

113 National Advisory Council on Aging, *Seniors in Canada 2006 Report Card*, 2006, p. 31.

114 *Ibid*, p. 34.

115 Byron Spencer, McMaster University, Evidence, November 27, 2006.

will not realize the coverage because they change jobs and the coverage will not go with them… That is really quite a serious concern among people who are in very low-income groups; they certainly are people who very rarely have any significant amount of private pension coverage."[116]

A recent study by Statistics Canada found a sharply widening gap in pension contributions between families at the top and the bottom of the earnings scale. The maturation of the Canada and Québec Pension Plans had led to a substantial reduction in income inequality between the early 1980s and the mid-1990s, but the now growing inequality in contributions towards retirement could make the distribution of family income among seniors more unequal in years to come.[117]

Another disincentive to continued labour force participation in the case of specific retirees such as teachers and nurses are pension caps. The Committee heard that, "Presently, we have a disincentive to getting people back into the workforce, with their cap in the pension at $58,000. If a teacher, for instance, gets $45,000 or $50,000 pension, as soon as he or she finds another type of employment, then starts getting $58,000 or $60,000, she is working for absolutely nothing. There is a disincentive now with the caps."[118]

Old Age Security and the Guaranteed Income Supplement

The Old Age Security (OAS) program provides a basic income to persons over 65 years of age who have lived in Canada for at least 10 years. Its benefits include the Old Age Security pension, the Guaranteed Income Supplement (GIS) and the Allowance for spouses. In 2005-2006, around 4.2 million people received OAS benefits, totalling $29 billion.[119]

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116 *Ibid*.

117 Statistics Canada, "Study: Pension coverage and retirement savings of Canadian families" in *The Daily*, 26 September 2006.

118 Robert Dobie, National Advisory Council on Aging, Evidence, November 27, 2006.

119 Human Resources and Social Development Canada, "C-36: An Act to Amend the Canada Pension Plan and the Old Age Security Act", November 28, 2006.

The Chief Actuary of Canada estimates that the number of people receiving OAS pensions will more than double from 2005 to 2030,[120] leading to a rise in the ratio of OAS expenditures to GDP from 2.4 per cent in 2010 to 3.2 per cent by 2030.[121] The Committee heard from Dr. Byron Spencer that "…government programs will remain manageable, at least in response to population aging. The popular view is that increases in health care costs, which everybody thinks are obviously attributable to population aging, will break the bank — in particular, break government budgets — and things will be unmanageable. I think this view simply is not true. It is not true of public pension programs and income security programs, and it is not true of health care programs."[122]

Similarly, in evidence to the Standing Senate Committee on Banking, Trade and Commerce earlier this year, the Chief Actuary of Canada confirmed that the retirement income "system is expected to be sustainable and affordable well into the future in the face of changing demographic conditions." Notwithstanding, "ongoing review of the system will help to ensure this remains the case."[123]

The Committee is also concerned to make sure that all efforts are being made to reduce the number of seniors who do not receive the OAS benefits for which they are eligible. The annual number of persons eligible to receive the GIS but who did not receive it decreased by 34 per cent between 1999-2001 and 2003.[124] Still, it is estimated that 3 per cent of the seniors population – approximately 137,000 seniors in 2003 – did not receive the GIS despite being eligible for it, losing benefits of $204 million in total. Service Canada's process for reaching out to seniors who fail to re-apply was the subject

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120 Auditor General of Canada, *Report of the Auditor General of Canada to the House of Commons,* Chapter 6: Old Age Security, November 2006.

121 Standing Senate Committee on Banking, Trade and Commerce, *The Demographic Time Bomb: Mitigating the Effects of Demographic Change in Canada*, June 2006.

122 Byron Spencer, McMaster University, Evidence, November 27, 2006.

123 Standing Senate Committee on Banking, Trade and Commerce, *The Demographic Time Bomb: Mitigating the Effects of Demographic Change in Canada*, June 2006.

124 National Advisory Council on Aging, Seniors in Canada 2006 Report Card, p. 33.

of some discussion between Committee members and witnesses from HRSDC and Service Canada, concerning whether there are language literacy barriers for seniors who receive notification only by letter.

While the Committee's hearings were being carried out, the Minister of Human Resources and Social Development Canada introduced legislation to amend the CPP and OAS, making it easier for seniors to apply for benefits and ease eligibilities for certain claimants. Bill C-36 would allow for ongoing renewal, waiving the requirement for a renewal application once an initial application has been made, allow the Minister of HRSDC to co-administer similar provincial benefits for seniors based on federal provincial agreements, and simplify the reporting of income for couples and seniors.[125]

OAS benefits are adjusted quarterly to keep pace with the Consumer Price Index, but the base amount of the GIS was last increased in 1985. Because wage increases have generally been higher than CPI increases over the last 20 years, the gap in standard of living between GIS recipients and the working-age population is growing.[126] In some cases, the GIS is insufficient to allow seniors, especially unattached seniors, to live above the low-income cut off. An unattached person who received only the OAS and GIS in 2004 had an annual income of $12,239 – an amount less than the low-income cut-off for urban areas.[127] The Committee heard from the Canadian Association for the Fifty-Plus that a band of supplementary income should be allowed without clawback of the GIS in order to help address this situation.

4.3 Volunteering

For many older adults, engaging in volunteer activities can offer an opportunity to continue using skills and provide a sense of purpose

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125 Human Resources and Social Development Canada, "C-36: An Act to Amend the Canada Pension Plan and the Old Age Security Act", November 28, 2006.

126 Georgina Barnwell, *Women and Public Pensions: Working Towards Equitable Policy Change*, An Initiative of the Women's Centres in the Western area of Nova Scotia, January 2006.

127 National Advisory Council on Aging, *Seniors in Canada 2006 Report Card*.

during a phase of transition in one's life. Unpaid work can add to one's sense of identity and place, and are a means of giving back to society as a whole.[128]

One of the biggest basins of volunteers is young seniors. The National Advisory Council on Aging spoke to the Committee about how young seniors are increasingly volunteering with older seniors. In 2000, seniors accounted for 17 per cent of all formal volunteer hours, even though they represented only 12 per cent of the population. While the number of seniors volunteering fell from 23 per cent to 18 per cent between 1997 and 2000, the average number of hours volunteered per capita rose from 202 to 269.[129]

The benefits of inter-generational volunteering were highlighted by CARP – Canada's Association for the 50-plus:

> **"There is a whole world of possibilities if we bring the young and the elderly together to exchange, learn and share from each other in terms of skills, experiences and ideas. Such inter-generational initiatives such as mentoring, counselling, consulting and coaching can augment the knowledge of both the young and the elderly, and create a dynamic, robust and productive workforce, community and society, and go a long way in dispelling ageist views."[130]**

The Committee's attention was also drawn to the distinction between formal and informal volunteering and the valuable role that informal social networks can play in supporting seniors:

> **"In Aboriginal communities, informal support is given by the cooperative nature of many communities, and is fundamental to allowing seniors to stay in those communities. There are things such**

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128 Statistics Canada, *Aging Well: Time Use Patterns of Older Canadians 2005*, July 2006.

129 National Advisory Council on Aging, *Seniors in Canada 2006 Report Card*.

130 Judy Cutler, CARP – Canada's Association for the Fifty-Plus, Evidence, December 11, 2006.

> **as food sharing. Especially in remote Inuit communities, where food prices may be so high, a lot of hunters will share their food with the seniors in the community, making the lives of those seniors that much easier."[131]**

CARP suggested to the Committee that measures be taken to strengthen the voluntary sector, including tax credits and compensation for volunteers, as well as financial support for a sound infrastructure for recruitment, screening, training, monitoring, evaluation and recognition.

4.4 Lifelong Learning

The slowing labour force growth rates that are expected highlight the need to maximize the human resource potential of all elements of the population. Witnesses emphasized to the Committee that older Canadians are mostly in good health and able to learn new information and skills, including technology. Lifelong learning for seniors is seen not only as a way of supporting seniors' participation in society and the economy, but also as a strategy to ensure the continuing prosperity and productivity of the nation.

4.5 Questions for Further Study

- What planning or coordination have governments done with respect to the anticipated needs for technical aids among seniors?
- Is there further action the federal government can or should take regarding mandatory retirement?
- Does the Targeted Initiative for Older Workers adequately address the employment issues faced by older workers?
- What specific pension reforms should be undertaken? Which countries have had the most success with pension reform and what can Canada learn from those experiences?

[131] Mark Buell, National Aboriginal Health Organization, Evidence, November 27, 2006.

- What can be done to improve portability of pension coverage?
- Should any changes in eligibility be considered for the CPP?
- Should the CPP benefit structure be adjusted to remove disincentives to postponing retirement?
- What can be done to increase private pension coverage and reduce inequalities in savings and investment for retirement?
- Should the impact of pension caps on labour force participation be examined, with a view to removing disincentives to continued employment?
- Should the GIS be adjusted to at least meet low-income cut off levels?
- Is further action needed to further reduce the number of seniors eligible for but not receiving the GIS?
- Should additional employment income be exempted from the GIS clawback?
- Should alternative means of communicating with seniors regarding their available benefits be considered?
- What steps should be considered to strengthen volunteering?
- How is the government addressing the issue of lifelong learning for seniors?

5. Health: Promotion, Prevention and Care

"Canadians are not only living longer but they also are living longer in good health."[132]

Various definitions have been used to measure 'healthy' aging. While some studies have defined health as the absence of disease or chronic conditions, it is more common to consider health in terms of an individual's functional impairment and positive health perceptions. This latter approach is the one taken by the World Health Organization, whose definition states that "Health is a state of

[132] Pamela White, Statistics Canada, Evidence, November 27, 2006.

complete physical, mental and social well-being and not merely the absence of disease or infirmity." Statistics Canada's recent analysis of healthy living among seniors verified four criteria for a senior to be considered in "good health": good functional health, independence in activities of daily living, positive self-perceived general health, and positive self-perceived mental health.[133]

Although the majority of Canada's roughly 4 million seniors were in good health in 2003, seniors remain disproportionately heavy users of the health care system. Seniors make up 13 per cent of the population, but they account for one-third of all hospitalizations, more than one-half of all hospital stays,[134] and 44 per cent of health care expenditures overall.[135] Nonetheless, the anticipated impact of the aging population on Canada's health care system from a financial sustainability viewpoint does not seem to be as serious as some might fear.

Dr. Byron Spencer told the Committee about a recent OECD study which isolated the effects of population aging on increases in health care expenditures in OECD countries over the last three decades. This study found that the portion of increases that was attributable to population aging was 11 per cent, a figure which was consistent with his own research findings. This position is backed up by Health Canada's Applied Research and Analysis Directorate, which, after undertaking a comprehensive examination of the implication of aging for the Canadian health care system, concluded that "…aging due to greater longevity, which has been the driver of population aging that has occurred to date, does not appear to put pressure on health care costs." Their analysis does show that, "…the aging that will start to occur as a result of the baby boom bulge will add to cost pressures, but these effects are smaller than the pressures arising from other drivers of health care costs, such as increases in utilization or new

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133 Statistics Canada, "Healthy Living Among Seniors" in *How Healthy Are Canadians? Health at Older Ages*, Health Report Special Issue, Supplement to Volume 16, Catalogue no. 82-003-XPE, February 2006, p.9.

134 Statistics Canada, "Health Reports: Seniors Health Care Use" in *The Daily*, February 7, 2006.

135 Margaret Gillis, Public Health Agency of Canada, Evidence, December 4, 2006.

treatments."[136] According to the OECD, it is advances in medical technology and rapid increases in health services which are in fact the main sources of long-term upward pressure on public spending on health.[137] Spending specifically on long-term care and formal care services, however, may see a higher demand increase than other sectors of health care as a result of the aging population.[138]

The International Federation on Ageing suggested to the Committee that a healthy aging perspective can inform a policy strategy which would have far-reaching impacts:

> **"After canvassing the aging policies and programs for many different countries not unlike Canada and reflecting on the work of our NGO members who represent 50 million older people in the world, I ask myself the question: What is the single broadest policy intervention that could in some way impact on each of these substantive issues? The answer is "healthy aging." My caveat to this term is that aging — growing old — is not a health issue, nor should we see it as a health issue in the future, but rather part of the life-course approach. I have a belief that aging starts at birth and throughout the life-course we experience changes in our life, and at times we need specialist services and care."[139]**

This perspective on healthy aging requires a long-term commitment to action on a wide range of influences or determinants – economic, health and social services, behavioural, social, personal and physical – which affect individuals, families and nations. Jane Barratt affirmed

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136 Sara Hogan and Jeremey Lise, "Life Expectancy, Health Expectancy, and the Life Cycle" in *Horizons*, Vol. 6, No. 2, p.17.

137 Organization for Economic Co-operation and Development, "Study Projects Growing Pressure on Public Health Spending Over and Above Effects of Ageing Society", February 9, 2006.

138 Organization for Economic Co-operation and Development, "III. Future Budget Pressures Arising from Spending on Health and Long-Term Care" in *OECD Economic Outlook 79*, 2006.

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

that a healthy aging policy orientation over the life-course can have long-term benefits, including economic returns, to society.

5.1 Health Promotion

The central concept behind health promotion is that health is determined by many interacting social, psychological, and biological factors that are amenable to intervention by individuals and society. The health promotion approach focuses on improving the health of the population by addressing these determinants of health.

Witnesses emphasized the importance of health promotion as part of an overall strategy to improve seniors' health and well-being.

> **"…an effective health system must place as much emphasis on health promotion as it does on health care. The causes of some serious conditions associated with aging will elude us, as will their prevention and treatment methods. However, many ill effects of chronic conditions associated with aging are avoidable."[140]**

By reducing the rates and impacts of some conditions, health promotion and disease prevention strategies improve the overall health of the population, and reduce some pressure on healthcare costs in doing so.

> **"Of our total health care expenditures, 44 per cent are attributed to seniors — who are 13 per cent of the population. We will have more Canadians over age 65 than under age 15 in the next 10 years. Studies show that health promotion and disease prevention strategies can help those who are aging well, those with chronic conditions and those who are at risk for serious health problems even late in life. It follows, then, that investments in health**

[140] Robert Dobie, National Advisory Council on Aging, Evidence, November 27, 2006.

> **promotion and disease prevention should also be a given."[141]**

The Royal Canadian Legion suggested that, "the integration of health promotion and preventative health measures into medical programs, coupled with more affordable housing options," would be a way of reducing overall health care expenditures.[142]

Once again, a key to effective health promotion outcomes is a life-course approach. The Canadian Association on Gerontology reminded the Committee that, "The term 'health promotion' we support and encourage, but healthy aging does not start at 65; it starts the day that one is born."[143]

The National Advisory Council on Aging urged that the prevention of falls and lifestyle changes related to physical activity and nutrition be given priority in promotion and prevention programs for the aging population.

5.2 Injury Prevention

Injuries can reduce seniors' independence, limit their activities, or even result in death. Seniors are injured at home more than any other location, with falls being the main cause of injury-related hospitalizations.[144] In 2003, 5 per cent of the senior population experienced a fall[145] and the Committee heard evidence from the Public Health Agency of Canada that falls are the second leading cause of seniors' deaths. The National Advisory Council on Aging reviewed some of the striking statistics on falls for the Committee:

> **"Also, did you know that every hour in Canada, an older person dies as a result of a fall? Close to 1**

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141 Margaret Gillis, Public Health Agency of Canada, Evidence, December 4, 2006.

142 Jack Frost, Royal Canadian Legion, Evidence, December 11, 2006.

143 Sandra Hirst, Canadian Association on Gerontology, Evidence, December 11, 2006.

144 Public Health Agency of Canada, *Report on Seniors Falls in Canada*, 2005.

145 National Advisory Council on Aging, *Seniors in Canada: 20006 Report Card*, 2006.

> **million seniors will experience at least one fall per year, and that fall causes 84 per cent of injury-related hospital admissions of seniors in Canada. An incredible amount of money — $1 billion annually in direct health care costs — is a result of falls. It is important to note that evidence has shown that the causes and impacts of falls can be reduced."[146]**

The magnitude of the problem of falls among older adults is reflected by a 300 per cent increase in publications on the issue between 1985 and 2005.[147] To reduce the incidence of falls among seniors, the Public Health Agency of Canada reported to the Committee that it has been active in a number of falls prevention initiatives, including education and information materials for seniors, and a 2005 report that provides comprehensive data on falls, injuries and deaths, evidence on risk factors and best practices for prevention.

The National Advisory Council on Aging found that the rate of injuries resulting in limitations and hospitalizations due to falls remained stable between 1998-99 and 2002-03. The Public Health Agency of Canada informed the Committee that it will be hosting a national forum to discuss seniors' falls surveillance data in 2007, involving falls prevention practitioners, surveillance experts and researchers from across Canada. The outcomes of this forum will be used to help design interventions to reduce falls. The Agency also noted that, "Because of our success with falls prevention, the World Health Organization is using our approach to conduct a similar project on a global scale."

5.3 Chronic Diseases

As people age, they are more likely to be afflicted with chronic conditions. A chronic condition is defined in Statistics Canada's National Population Health Survey as a long-term health condition that has lasted or is expected to last six months or more and that has been

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146 Robert Dobie, National Advisory Council on Aging, Evidence, November 27, 2006.

147 Public Health Agency of Canada, *Report on Seniors Falls in Canada*, 2005.

diagnosed by a health professional.[148] The most common chronic conditions affecting seniors are heart disease, arthritis, diabetes and dementia.[149]

The Committee heard that because the number of seniors is increasing, particularly in the 85-plus group, the prevalence of chronic disease is increasing, and is expected to continue to grow. "In 2005, 91 per cent of seniors reported one or more chronic health condition as diagnosed by a health professional, compared with 87 per cent in 2000-01."[150] The National Advisory Council on Aging warned that the growth in the number of chronic conditions may end up, "…posing a number of challenges for health care."

The Aboriginal population is especially affected by chronic conditions. The National Aboriginal Health Organization told the committee that, "one in five Métis report arthritis or rheumatism, in comparison to one in ten in the non-Aboriginal population." First Nations seniors also report suffering from, "a variety of concurrent, long-term health conditions such as arthritis, rheumatism, high blood pressure, asthma and heart disease. Additionally, type 2 diabetes is also a cause of significant concern in elderly First Nations people."[151]

The Canadian Association on Gerontology reminded the Committee that healthy aging begins at birth. "The chronic condition does not start when one turns 65. It has its roots in the 30s and 40s."[152] This re-emphasizes the value of a life-course perspective on healthy aging, suggesting once again that strategies for reducing the prevalence of chronic disease in later life need to include the targeting of determinants and risk factors earlier in life.

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148 Statistics Canada, "Health at Older Ages" in Health Reports Special Issue, Supplement to Volume 16, 2006, p. 52.

149 Robert Dobie, National Advisory Council on Aging, Evidence, November 27, 2006.

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

151 Carole Lafontaine, National Aboriginal Health Organization, Evidence, November 27, 2006.

152 Sandra Hirst, Canadian Association on Gerontology, Evidence, December 11, 2006.

5.4 Medication Use

Seniors use a variety of medications to cope with chronic conditions such as diabetes, arthritis, or high blood pressure. In 2003, 9 out of 10 non-institutionalized seniors reported having taken at least one type of medication in the previous month. On average, they took three different types. These high rates of medication use, particularly with multiple medications, make medication safety a critical issue, especially concerning the possibility of drug interactions.[153] Studies have revealed that between 18 and 50 per cent of drugs taken by seniors are not used appropriately. It is not surprising, then, that between 19 and 28 per cent of hospitalizations of patients over the age of 50 are attributable to medication problems.[154]

In an effort to reduce complications related to multiple prescriptions and drug interactions, the Institute of Aging indicated that the health transition fund had supported a number of demonstration projects involving pharmacists working collaboratively with physicians, sharing full profiles of medications that may be prescribed by different physicians and reviewing potential interactions. One of the recommendations emerging from the health transition fund research addresses the integration of pharmacists and physicians based on these experiences.

Additionally, the cost of medications can be overwhelming for seniors living on a fixed income. The Committee heard that,

> **"While virtually all seniors are covered by some type of prescription drug insurance, either public or private, the extent of this coverage varies significantly from province to province, leaving many seniors vulnerable to financial hardship. In its special report to the Romanow Commission on the Future of Health Care in Canada, NACA recommended that a national comprehensive**

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153 Public Health Agency of Canada, *The Safe Living Guide*, 2005, p. 21.

154 National Advisory Council on Aging, *1999 and Beyond, Challenges of an Aging Canadian Society*, Ottawa, 1999, p. 31.

publicly-insured or publicly-privately-insured prescription plan be established."[155]

5.5 Mental Health, Mental Illness and Dementia

As is also often the case with the population at large, issues that relate to the mental health of seniors are not always given the priority they deserve. In this vein, Margaret Gillis told the Committee that:

> **"Seniors' mental health is often overlooked. Problems such as depression are often viewed as an inevitable part of aging. In fact, mental health problems in later life occur in the context of mental illness, disability and poor social support."[156]**

The impact of mental illness and dementia on the older population is considerable. For example:

- **Studies suggest that between 15 per cent and 25 per cent of nursing home residents have symptoms of major depression, and another 25 per cent have depressive symptoms of lesser severity.[157] The prevalence of mental disorders in general among nursing home residents is extraordinarily high, between 80 per cent and 90 per cent.[158]**
- **The incidence of suicide amongst men 80 years of age and older is the highest of any age group (31 per 100,000).[159]**
- **Dementia affects approximately 8 per cent of all people aged 65 and over, and almost 35 per cent of**

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155 Robert Dobie, National Advisory Council on Aging, Evidence, November 27, 2006.

156 Margaret Gillis, Public Health Agency of Canada, Evidence, December 4, 2006.

157 Canadian Coalition on Seniors' Mental Health (CCSMH) brief to the Standing Senate Committee on Social Affairs, Science and Technology, p. 4.

158 Standing Senate Committee on Social Affairs, Science and Technology, *Interim Report on Mental Health Mental Illness and Addictions in Canada*, 2004, p. 88.

159 CCSMH brief, *op. cit.*, p. 5.

> **persons aged 85 and over. It has been estimated that by 2031, over 750,000 Canadians will have Alzheimer's disease and related dementias (up from 364,000 in 2003).[160]**

In her testimony to the Committee, Judy Cutler noted that there is currently no comprehensive strategy for addressing mental health issues in Canada, including those that affect seniors in particular:

> **"As well, a national mental health strategy as outlined in the Kirby-Keon report would contribute to the health and quality of life of caregivers and care recipients. It is unconscionable that Canada is the only G8 country without such a strategy to serve millions of those suffering from mental illnesses. We are concerned about the aging of the mentally ill, whose needs are specific, unique and ignored."[161]**

This points to the way that mental disorders experienced by older adults may differ from those experienced by younger people, which can make accurate diagnosis and treatment difficult. For example, depression is often under-diagnosed and under-treated because it is confused with or masked by other problems, or because the observed symptoms are considered to be part of the normal aging process. In addition, seniors typically have co-morbidities which complicate issues of assessment and treatment.

And, as Margaret Gillis told the Committee:

> **"Similarly, Alzheimer's disease and related dementias represent a crucial health issue among seniors, their families and caregivers. We now have evidence that early intervention can delay progress of the disease."[162]**

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160 *Ibid*.

161 Judy Cutler, CARP - Canadian Association for the Fifty Plus, Evidence, December 11, 2006.

162 Margaret Gillis, Public Health Agency of Canada, Evidence, December 4, 2006.

Timely diagnosis can allow for the use of effective therapies which can 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. However, the diagnosis of dementia can be complicated because there are other disorders that coexist with Alzheimer's disease or have similar features to it.

5.6 Palliative Care

Palliative care "offers the relief of pain and other symptoms; it seeks to meet not only the physical needs but also the social, psychological, emotional, and spiritual needs of persons with terminal illness, their families, caregivers and other loved ones."[163] Palliative care may be received at home, in a hospital, in long-term care facilities, or in hospices.

There are several dimensions to adequately addressing palliative and end-of life care issues for seniors. A 2004 poll indicated that 90 per cent of Canadians wish to remain in their own homes during the final stages of life, yet about 75 per cent of deaths today still take place in hospitals and long-term care facilities.[164] There is a shortage of health care professionals trained in palliative care and in geriatric medicine. Caregivers who are offering palliative and end-of-life care also require ongoing training and support, as only 6 per cent of informal caregivers feel they can adequately care for their loved ones without additional support.[165] New indicators and data need to be developed to better measure palliative and end-of-life care.[166] Across the country, programs and services available to those at end-of-life vary from jurisdiction to jurisdiction, as do the eligibility criteria for those services.

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163 National Advisory Council on Aging, *1999 and Beyond, Challenges of an Aging Canadian Society*, Ottawa, 1991, p.35.

164 Canadian Hospice Palliative Care Association, Fact Sheet, September 2004.

165 *Ibid*.

166 National Advisory Council on Aging, *Seniors in Canada: 2006 Report Card*, 2006, p.25.

One of the most important initiatives to support Canadians at end-of-life was the implementation of the Compassionate Care Leave Benefit[167] under the *Employment Insurance Act* in 2004. Human Resources and Social Development Canada (HRSDC) pointed out to the Committee that the government had recently expanded the definition of "family member" to make it easier for Canadians to take advantage of the benefit. However, there are still a number of deficiencies with the program, especially in regards to the length of the benefit and the qualification that the gravely-ill individual is at risk of dying within the next six months. Officials from HRSDC indicated that research is currently ongoing within the Department on compassionate care and other issues regarding caregiving, such as respite care.

> **"For many of those issues, you really would have to take a different approach to it, rather than the EI vehicle itself. Our sense is we may have gone as far on the Employment Insurance vehicle as we can. When you look at these broader issues, it might make sense to look at a broader set of instruments."[168]**

Witnesses before the committee pointed to the Veterans Affairs Canada palliative care program for at-home care as a potential model of palliative care. Veterans Affairs Canada reported that it is currently undergoing a health-care program review and will be examining how the department handles end-of-life care interventions to ensure a comprehensive approach to the handling of their clients needs in this area. As part of the health-care review, they "want to look at what are the necessary interventions at the right place and time, as opposed to looking at criteria based on eligibility that is largely driven by entitlement as opposed to need."[169]

> **"Oftentimes these palliative cases do not have a particular time frame associated with them. The**

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167 The Benefit provides up to six weeks of paid leave to qualified persons who may need to leave work to provide care or support to a gravely-ill family member who is at risk of dying within six months.

168 Peter Hicks, Human Resources and Social Development Canada, Evidence, December 4, 2006.

169 Bryson Guptill, Veterans Affairs Canada, Evidence, December 4, 2006.

> **expectation might have been that someone would only be living for a short period of time. In some cases, they lived longer. You cannot have an artificial time limit around palliative care in those situations. I am pleased to say we have been very flexible in our policy in that sense. Our intention would be to help people in the home environment in any cases where it is possible. That sometimes is restricted…"[170]**

5.7 Caregiving, Paid and Unpaid Caregivers

Unpaid Caregivers

The aging population is translating into an increased requirement for individuals to care for family members or friends who have chronic health problems or disabilities. As people age and they deal with various health conditions, they will require some type of assistance with housework, personal chores, or health-related home care services. For some, this caregiver role is filled by a spouse, a family member, or a friend. Caregiving can range from a few hours a week to round-the-clock care. These informal caregivers are a vital part of the health care system, both for seniors at home and in institutional care. They provide about 80 per cent of all home care to seniors living in the community and up to 30 per cent of services to seniors living in institutions.[171]

> **"In 2002, more than 1.7 million adults aged 45 to 64 provided informal care to almost 2.3 million seniors with long-term disabilities or physical limitations. Roughly equal numbers of men and women aged 45 to 65 are involved in informal caregiving. Women are more likely to be high intensity caregivers, while men work longer hours at paid employment. Yet most of these caregivers are also in the labour force,**

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170 *Ibid*.

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

> **with 70 per cent being employed. Just under half of these employed caregivers were women. One third of male caregivers spent one hour or less per week providing care compared with less than a quarter of women. Women are more likely to spend four or more hours per week."[172]**

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

> **"Two thirds of women and nearly half of men who combined more than 40 hours of employment with four or more hours of caregiving per week experienced substantial job related consequences such as reduction in hours or income or change in work patterns."[173]**

Witnesses pointed out that Canada's informal caregivers, many of whom are seniors themselves, also need support.

> **"The added responsibility of informal caregiving can lead to physical and mental exhaustion and have a detrimental effect on the health of caregivers. Lack of formal supports can lead to burn out, causing caregivers to withdraw from caregiving. This, in turn, can lead to higher rates of institutionalization for seniors. In any case, future generations of seniors will not be able to count on large families to provide personal care and will likely be more reliant on public services."[174]**

To offset the physical, mental, emotional and financial challenges faced by caregivers, CARP – Canada's Association for the Fifty Plus has called for a national respite program and a national home care

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172 Pamela White, Statistics Canada, Evidence, November 27, 2006.

173 *Ibid*.

174 Robert Dobie, National Advisory Council on Aging, Evidence, November 27, 2006.

program "that includes chronic and community non-medical care with government transparency and accountability."[175]

To enable caregivers to balance work and caregiving, CARP also recommended establishing policies for flexible work hours and reasonable leaves of absence. Where there is a need for a substantial leave of absence from work to provide elder care, they suggested income protection similar to that of the Compassionate Care Leave Benefit under the *Employment Insurance Act* and for amendments to the Canada Pension Plan similar to those extended to new parents. CARP also noted the difficulty faced by caregivers in re-entering the workforce once caregiving has ceased and noted the "need to have post caregiving support systems to help build or rebuild skills and build confidence for a successful transition back into life and into the labour market."[176]

Witnesses advised the Committee to be mindful of the importance of informal social supports such as food sharing in Aboriginal communities. "In Aboriginal communities, informal support is given by the cooperative nature of many communities and is fundamental to allowing seniors to stay in those communities."[177] Officials from Health Canada echoed the importance of families and the informal care system for elderly aboriginal Canadians, stating that their research indicates that some caregivers are caring for up to five relatives each day, requiring a system that supports both the clients and their families.[178]

Paid Caregivers

According to Anne Martin-Matthews, Scientific Director of the Canadian Institutes of Health Research's Institute of Aging, there are approximately 32,000 individuals, primarily women, providing home support care such as bathing, feeding, toileting and dressing to

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175 Judy Cutler, CARP - Canadian Association for the Fifty Plus, Evidence, December 11, 2006.

176 *Ibid*.

177 Mark Buell, National Aboriginal Health Organization, Evidence, November 27, 2006.

178 Shelagh Jane Woods, Health Canada, Evidence, December 4, 2006.

seniors. Many have little training and are paid on a per-visit basis to a home.[179] Unfortunately, as Sandra Hirst stated to the Committee, "there is no consistent standard of care nationally as to how we actually give physical, psychological and emotional care to older adults."[180]

Furthermore, many personal care workers without any education or training are hired by families, nursing homes and long-term care institutions to assist seniors. According to Lynn MacDonald, Scientific Director of the National Initiative for Care of the Elderly, many "are being paid under the table; are not being paid minimum wage; are hidden much of the time; and would likely belong to the cadre that you are speaking of that require a great deal of education."[181]

> **"In considering the education aspects, we have to respect how important it is in relation to professionals. Over the next 10-15 years, we will need an additional 32,000 home support workers to meet that future need. Yet, we are not recruiting to those fields. The minute people have sufficient training; they go to work for long term care facilities, where they can have continuity of payment. They know what job they will do from day to day. The way in which the delivery of home support services is structured, they cannot know what job they will do each day or where it will be done. I would like to plea for recognition of that full continuum of workforce that we need in respect of our aging population."[182]**

179 Anne Martin-Matthews, Institute of Aging, Evidence, December 11, 2006.

180 Sandra Hirst, Canadian Association on Gerontology, Evidence, December 11, 2006.

181 Lynn McDonald, National Initiative for the Care of the Elderly, Evidence, December 11, 2006.

182 Anne Martin-Matthews, Evidence, December 11, 2006.

5.8 Long-Term Care, Continuing Care and Home Care

In general, long-term care facilities provide living accommodation for people who require on-site delivery of 24-hour, 7-days-a-week supervised care, including professional health services, personal care and services such as meals, laundry and housekeeping. Long-term, facilities-based care is not publicly insured under the *Canada Health Act*. The Committee was told that,

> **"From a facility perspective, there is no clear definition of long-term care nationally. Each province and territory employs different terms to describe the experience. The staffing requirements and legislation that governs these facilities differ across Canada."[183]**

This also means that, across the country, jurisdictions offer a range of services and cost coverage. Consequently, there is little consistency across Canada in what facilities are called (e.g., nursing home, personal care facility, residential continuing care facility, etc.), the level or type of care offered and how it is measured; how facilities are governed or who owns them.[184]

To deal with those inconsistencies, the Royal Canadian Legion indicated that it has been advocating for national standards of long-term care. "When seniors and veterans face the reality of transitioning to those facilities, there should be a well-defined level of care, which should be the same whether they reside in Newfoundland and Labrador or British Columbia. Seniors should be covered by a seniors' bill of rights to establish national standards of care, benefits and services."[185]

The Committee heard that most older people will not enter institutional care. According to the International Federation on Ageing,

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183 Sandra Hirst, Canadian Association on Gerontology, Evidence, December 11, 2006.

184 This description of long-term care is taken from the website of Health Canada at: www.hc-sc.gc.ca/hcs-sss/home-domicile/longdur/index_e.html

185 Jack Frost, Royal Canadian Legion, Evidence, December 11, 2006.

only "One in seven people over the age of 75 in developed countries are likely to go into some institutional care." The National Advisory Council on Aging provided a portrait of the long-term care situation in Canada:

> **"Approximately 7 per cent of all seniors and as many as 40 per cent of the very old, presently reside in long-term care facilities due to health problems. While future generations of seniors might be less prone to living in long-term care facilities, the sharp increase among very old seniors in years to come will place considerable pressure on long-term care systems. Increasingly, these facilities are called on to care for seniors who are older and sicker than they were in the past. The organization and funding of health care, as well as the hiring, training, and remuneration of health personnel, must adjust to this new reality."[186]**

The care required in long-term care facilities is indeed changing, becoming more demanding and complex. The Canadian Association on Gerontology noted: "we are asked to provide care to complex older adults who have a variety of needs. Older adults entering long-term care rarely present with one health issue. They have multiple concerns."[187] Instead of investments in personnel training and expansions in the staff teams at long-term care facilities, staff in many provinces have had to cope with cutbacks. "Where we had registered nurses, for example, we are now using licensed practical nurses – LPNs – or registered psychiatric nurses. Where we had LPNs, we are now using nurse's aides, because of funding."[188]

The increasing ethnocultural diversity of seniors in long-term care facilities poses a challenge for some institutions, which can have difficulty understanding and adapting to the needs of seniors from

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186 Robert Dobie, National Advisory Council on Aging, Evidence, November 27, 2006.

187 Sandra Hirst, Canadian Association on Gerontology, Evidence, December 11, 2006.

188 *Ibid*.

different ethnocultural backgrounds. Douglas Durst told the Committee that for these seniors, even beyond immediate issues of language, diet, and customs, "…attitudes about receiving and accepting help, dependency, self sufficiency, and so on, are different, as is wanting and asking for help from professionals…"[189] Culture-specific facilities were identified by the Canadian Association on Gerontology as a possible solution to providing culturally-adapted, facility-based care.

An emerging subgroup of older adults in society and long-term facilities is adults with intellectual and developmental disabilities. The Canadian Association on Gerontology told the Committee that, "We have populations now in their 40s who are demonstrating Alzheimer's-like symptoms. By the time they reach 60, at least 50 per cent of individuals who have Down Syndrome will develop Alzheimer's-like symptoms." As their families age, these adults are admitted to long-term care. "Regardless of the setting in which care is delivered, this subgroup of our senior population will warrant our attention."[190]

A number of witnesses suggested that a national home care program could be a cost-effective way of delivering medical services to seniors that contributes to their quality of life. As with long-term care, "Every province and the territories have different home care programs all with different eligibility programs, different levels of care, different amounts of care, and so forth. The different programs create a patchwork quilt across the country. We have advocated for a national home care program with standards and with the provision of core services comparable from province to province…"[191] CARP specified that a national home care program should include chronic care and home and community support services, and not be restricted to acute care and medical care.

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189 Douglas Durst, University of Regina, Evidence, November 27, 2006.

190 Sandra Hirst, Canadian Association on Gerontology, Evidence, December 11, 2006.

191 Judy Cutler, CARP – Canada's Association for the Fifty Plus, Evidence, December 11, 2006.

Jane Barratt of the International Federation on Ageing provided the example of Australia as a model for the development of a national home care program.

> **"I was intimately involved with a national home care program that was equitable across the provinces. The program had national standards that were met through consensus with the provinces and had accreditation with the approved providers. Services ranged from community-aged care packages — packages of care that were worked out with the person receiving the care and their family in the home — right up to what were called "EACH" packages, or Extended Aged Care in the Home. Those packages were more detailed and had intensive nurse care. I am aware of and have been closely involved with national programs that have a track record of 15 years. They extended to rural and remote areas, the indigenous population and culturally specific programs called culturally and linguistically diverse — CALD — programs in different languages."[192]**

Within Canada, the New Brunswick Extra-Mural Program (known by many as the 'hospital without walls') was suggested by the National Advisory Council on Aging as an innovative model for the delivery of comprehensive home health care services.

The Committee heard that the greatest current weakness in home care services across the country is the provision of home support services delivered primarily by non-professional or paraprofessional workers that provide most of the paid home care services in the country.

> **"This particular cadre of individuals are perhaps the lowest paid, work with the fewest benefits, often pay for their own training, in some provinces pay**

[192] Jane Barratt, International Federation on Ageing, Evidence, December 11, 2006.

> **their own travel expenses, and so on. Yet these people are relied upon to provide the bulk of home care services. … It is critical that this group of individuals be an integral component of a national home care program. When we think of home care, we tend to think of professional services but paraprofessionals are the bedrock of the home care programs."[193]**

The lack of a national human resources strategy and training standards for this sector has a significant impact on the quality of care from one region to another.

> **"There is an urgent need for a national human resources strategy in home care across the country because the supply and distribution of home care workers varies tremendously across the country. Many provinces are recruiting from out of country to try to enlist home care workers in Canada. That supply and distribution is critical to an equitable provision of services across the country within the home care sector itself."[194]**

5.9 Strengthening the Gerontological / Geriatric Healthcare Workforce

As the population ages, there will be an increasing demand for healthcare professionals and medical specialists to treat seniors.

Recent consultations with seniors' organizations by the National Institute of Aging found that the top health issues for seniors included training in standards of practice for clinicians who work with older adults, and access to age-appropriate health service, which is limited by the acute shortage of geriatrics specialists.[195] "We need more

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193 Taylor Alexander, CARP – Canada's Association for the Fifty Plus, Evidence, December 11, 2006.

194 *Ibid*.

195 Anne Martin-Matthews, National Institute of Aging, Evidence, December 11, 2006.

people dedicated to careers in geriatrics and gerontology, and to basic research on the biological aspects of aging, all with the goal of improving health services delivery to an aging and elderly population."[196]

For example, the Committee heard that in 2000-01, seven medical students went into geriatric medicine in the entire country.[197] In 2000, there were 144 geriatricians in Canada, compared to an estimated 481 that were needed. By 2005, the number of geriatricians had risen to 191, but was still far short of the 538 that were estimated to be needed in 2006.[198]

Compounding the challenge of the existing shortage is that the current healthcare workforce is itself aging, and recruitment numbers are not meeting current or projected demand. The Canadian Association on Gerontology reported to the Committee that already, "The average age of a registered nurse in this country is close to 50." Attracting young people to the field of aging was a challenge mentioned by a number of witnesses.

Lynn McDonald cited a lack of professional training and education in geriatric medicine, gerontological social work and gerontological nursing as a key impediment to attracting and producing the number of health professionals needed. Beyond gerontological and geriatric specialists, the incorporation of interdisciplinary geriatric education into the core education program of all health professionals would improve the ability of the health care field on the whole to offer age-appropriate services.

Finally, Anne Martin-Mathews suggested that finding a way to recognize the credentials of immigrants with health care training would also help alleviate the shortage of health care professionals.

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196 *Ibid*.

197 Sandra Hirst, Canadian Association on Gerontology, Evidence, December 11, 2006.

198 National Advisory Council on Aging, *Seniors in Canada 2006 Report Card*, 2006, p.19.

5.10 Questions for Further Study

- What cost pressures can be anticipated on long-term care and formal care services, and what can be done to mitigate or best meet those needs?
- Are health promotion efforts getting the priority they deserve compared to health care or other issues?
- Are falls prevention initiatives having an effect in reducing the number of falls in recent years, and have they explored the role of complex medical interactions in falls?
- What is being done, and what needs to be done, to reduce the higher rates of chronic illnesses among Aboriginal populations, and aboriginal seniors?
- Have promising practices been implemented to reduce medication-related complications and interactions? What measures are in place to avoid negative drug interactions with both prescription and over-the-counter medications?
- What would be the costs and advantages of a national, comprehensive, publicly-insured or publicly-privately-insured prescription plan as recommended by the National Advisory Council on Aging?
- What early interventions should be taken to delay progress of mental illness among seniors? What action is being taken by the government in response to the Standing Senate Committee on Social Affairs, Science and Technology's report Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada, including issues related to seniors' mental health?
- What changes are being proposed to the Veterans Affairs Canada model of palliative care, and should it be considered as a template for a broader program for all Canadian seniors?
- What would be the costs and advantages of a national respite program and a national home care program as recommended by witnesses?

- How can better recruitment, training, support and employment conditions be provided to the paid homecare and home support sector?
- Is any work being done on establishing national standards of care for long-term care facilities or home care?
- What is being done to meet the anticipated need for geriatric and gerontological health professionals?

6. Housing and Transport

Appropriate services and infrastructure can help seniors maximize their independence and quality of life as they age. Seniors today require a broad range of housing options that reflect their personal preferences and meet their physical, mental and social needs. In addition, access to transportation can play a significant role in maintaining seniors' independence, social networks and quality of life.

The National Advisory Council on Aging recommended increased funding for affordable housing and public transit, "in both rural and urban areas because housing and transportation are key to seniors' autonomy and social participation -- two ingredients that benefit Canadian society as a whole."[199]

A wide range of terms are used in different jurisdictions and among different researchers and stakeholders to identify the variety of housing arrangements and non-medical support services available for seniors. For the purposes of this interim report, we look at housing, home and community support services, assisted living and supportive housing.

6.1 Housing

In 2001, there were a total of 2.4 million senior-led households in Canada. The vast majority of seniors – 93 per cent – lived in private

[199] Robert Dobie, National Advisory Council on Aging, Evidence, November 27, 2006.

dwellings, with the remaining 7 per cent residing in collective settings such as health care institutions, shelters, religious establishments and others. Among seniors over 75, the number living in collective dwellings is higher at 13 per cent, down slightly from 14 per cent in 1996.[200]

A significant difference between senior and non-senior households can be found in the rate of persons living alone. Among senior-led households, 43 per cent were persons living alone, compared to 21 per cent of non-senior households. The majority of seniors living alone were women, and those who lived alone were most likely to be renters.[201]

The Canada Mortgage and Housing Corporation (CMHC) reported to the Committee that most seniors in Canada are well-housed, meaning that their housing is in adequate condition, suitable in size to meet their needs and affordable, requiring less than 30 per cent of their pre-tax household income. "Over two thirds of senior-led households own their own home, 85 per cent of these home owners are mortgage free and 57 per cent of them live in single detached dwellings."[202]

There were, however, 17 per cent of senior households who lived in 'core housing need' in 2001, a slight decrease from 18 per cent in 1996, but still higher than the non-senior household rate of 13 per cent.[203] 'Core housing need' refers to households that are crowded, in poor condition or did not have affordable shelter. Affordability was the main reason why Canadian senior households fell into core housing need.[204] Affordability problems were four times more common with

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200 Canadian Mortgage and Housing Corporation, *Research Highlight Socio-Economic Series*, "2001 Census Housing Series: Issue 9 Revised The Housing Conditions of Canada's Seniors," April 2005.

201 *Ibid*.

202 Douglas Stewart, Canada Mortgage and Housing Corporation, Evidence, December 4, 2006.

203 National Advisory Council on Aging, *Seniors in Canada 2006 Report Card*, 2006.

204 Douglas Stewart, Canada Mortgage and Housing Corporation, Evidence, December 4, 2006.

senior renters than with senior homeowners, and also disproportionately affected seniors living alone.[205]

The National Aboriginal Health Organization emphasized the particular housing challenges facing Inuit seniors. Up to 31 per cent of senior-led Inuit households faced core housing need in 2001.[206]

> **"Regarding housing, Inuit seniors are especially affected, as they must either live within their children's multi-generation crowded homes or have other family members move into their small subsidized residences. Inuit seniors in Northern Canada live within a fragile infrastructure which impacts on housing and the high cost of living threatens their already minimal income."[207]**

Seniors with disabilities, recent senior immigrants, and the broader Aboriginal senior population also have higher levels of core housing need than their non-senior counterparts.

The most pressing current housing issues facing seniors, according to CHMC, are "housing affordability, the need for more housing options, and the coordination of housing with services that support independent living."[208] These points echoed remarks made to the Committee by Robert Dobie of the National Advisory Council on Aging, who highlighted the urgency of investments in social housing.

> **"The lack of investment in social housing is another issue that must be considered. Many seniors cannot afford upscale private "adult lifestyle" or retirement**

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205 National Advisory Council on Aging, *Seniors in Canada 2006 Report Card*, 2006.

206 *Ibid*.

207 Carole Lafontaine, National Aboriginal Health Organization, Evidence, November 27, 2006.

208 Douglas Stewart, Canada Mortgage and Housing Corporation, Evidence, December 4, 2006.

> **homes. Seniors' housing developments should not focus on "the gold in the grey" only."**[209]

CMHC provides federal funding for 633,000 social housing units, of which about one third are occupied by seniors. The agency told the Committee that it is currently working with provinces and territories on the delivery of the $1 billion Affordable Housing Initiative, with most provinces "using a portion of that funding for affordable rental housing for seniors, including supported housing."[210]

CMHC also indicated that it spends "about $2 billion a year in support of the existing housing stock. Most of that money actually is transferred to provinces for the administration of existing public and social housing units."[211]

As well, CMHC offers programs for residential rehabilitation and home adaptations to reduce the costs of repairs and minor home adaptations that allow seniors to stay in their homes longer. However, the need for these in the future could be greatly reduced if the most recent building standards and designs are used in new constructions.

> **"The National Building Code actually has accessibility standards within them, so to the extent that the National Building Code is adopted by provincial agencies as their building code, or is adapted to meet their needs, a certain level of accessibility will apply. I also mention a concept that CMHC has developed over the years and we call it Flex Housing. The idea is that the design and construction of the house will allow that house to grow with its occupants. So as the family grows, the number of rooms in the house can expand as the family; as the kids leave, those rooms can contract. But also, if you are careful about how you design hallways and doorways and the positioning of**

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209 Robert Dobie, National Advisory Council on Aging, Evidence, November 27, 2006.

210 Douglas Stewart, Canada Mortgage and Housing Corporation, Evidence, December 4, 2006.

211 *Ibid*.

bathrooms, as the family ages you can accommodate varying degrees of disability."[212]

6.2 Home and Community Support Services

The Canadian Association on Gerontology told the Committee that, "The vast majority of seniors wish to live in their own homes… Aging in place is a preferred future, but it should not be defined by financial means or physical limitations or capabilities. Opportunities must be provided for all seniors to have access to services such as mowing the lawn, snow shovelling and grocery delivery that will support their ability within their own homes, and will support the choices they want to make."[213] A national home care program that expanded seniors' choice of living arrangements was recommended by the Canadian Association on Gerontology.

The Committee heard that both seniors and public services benefit from programs supporting aging in place. The National Advisory Council on Aging indicated that keeping seniors at home and in their setting as long as possible with the support of support services or assisted living programs is "much cheaper, a third of the price and quality of life is so much better," compared to institutionalization. The Royal Canadian Legion recommended the creation of a needs-based 'Seniors Independence Program' for all Canadian seniors, modelled after the Veterans Independence Program (VIP) that is offered by Veterans' Affairs Canada. The VIP provides "personal care, housekeeping and grounds maintenance in order to help veterans and their survivors remain healthy and in their own homes to the extent possible and for as long as possible."[214] The Legion suggested that such a program, extended to all Canadian seniors, could "…reduce the hospital expenditures for hospitalization and long-term care."[215]

Ensuring that immigrant families have the support and resources needed to care for seniors at home also requires attention. Douglas

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212 *Ibid*.

213 Sandra Hirst, Canadian Association on Gerontology, Evidence, December 11, 2006.

214 Bryson Guptill, Veterans Affairs Canada, Evidence, December 4, 2006.

215 Jack Frost, Royal Canadian Legion, Evidence, December 11, 2006.

Durst told the Committee, "Reaching that population of family reunification immigrants and making sure they get adequate support and care while they are still in their family, is one method whereby we can make sure they have a high standard of life, high quality of life, and, in fact, will have less demand on the services later."[216]

In terms of services to the Aboriginal population, Health Canada reported that 95 per cent of First Nations and Inuit have access to basic home care services through the First Nations and Inuit Home and Community Care Program which was created seven years ago. This program serves seniors, persons with disabilities and persons suffering from chronic illness, with 50 per cent of its clients last year over age 65. It is Indian and Northern Affairs Canada (INAC), through its Assisted Living Program, that provides "non-medical social support services to First Nations people who have functional limitations because of age, health problems or disabilities, to help them maintain their independence, to maximize their level of functioning and to enable them to live in conditions of health and safety."[217]

Indian and Northern Affairs Canada reported that they are working closely with Health Canada and 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."[218] The goal of this initiative is to develop a seamless approach to the delivery of services provided by Health Canada, INAC and, in some instances, provincial departments.

Witnesses, however, suggested that support services for Aboriginal seniors were inadequate in many cases. Douglas Durst cited cases of Aboriginal persons in poor health leaving a reserve to come to the city for formalized medical services and hospital care, but then returning home, where "there is a reoccurrence of the same kinds of issues and problems."[219] Inadequate medical and support services on reserves can exclude Aboriginal seniors from the benefits of living at home with

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216 Douglas Durst, University of Regina, Evidence, November 27, 2006.

217 Havelin Anand, Indian and Northern Affairs Canada, Evidence, December 4, 2006.

218 *Ibid*.

219 Douglas Durst, University of Regina, Evidence, November 27, 2006.

their family. The Committee heard from the National Aboriginal Health Organization that, "In reality on reserves, you do not have the support. You do not have the doctors, nurses or support system to give that care at home. The ability to provide nutritious meals and so on sometimes is not doable."

6.3 Assisted Living and Supportive Housing

As people age, there is often a gradually increasing need for assistance with daily activities to support independent living. Between the two poles of independent living and institutional living there are a wide range of settings which combine independent housing with support services.

The terms used to describe these settings often vary from one province or region to another, and even when the same term is used, its definition may differ. Two of the most frequently used terms are 'assisted living' and 'supportive housing.'

According to the Public Health Agency of Canada, the term 'assisted living' refers to supportive housing, congregate housing, and other settings which offer personal care as well as housekeeping, laundry, meals, and recreational opportunities. "Retirement homes, residential care homes and assisted living facilities vary in location, size, price, amenities, programs and services. The mix of staff and residents also contributes greatly to the 'personality' of each place."[220]

Similarly, CMHC describes 'supportive housing' as "the type of housing that helps people in their daily living through the provision of a physical environment that is safe, secure, enabling and home-like and through the provision of support services such as meals, housekeeping, and social and recreational activities. It is also the type of housing that allows people to maximize their independence, privacy,

[220] Canadian Health Network, Public Health Agency of Canada. "I want to stay as independent as I can. What are some options for seniors' housing besides nursing homes or other facilities?" consulted online, January 2007.

decision-making, and involvement, dignity and choices and preferences."[221]

The National Advisory Council on Aging emphasized to the Committee that this type of housing is a topic requiring attention.

> **"There is also a need to develop alternatives to institutionalization such as supportive housing and assisted living. Supportive housing and assisted living can serve as an intermediate solution for seniors who require more care than is possible to provide at home, but less than that provided in extended care facilities. … Planning for an aging society calls for an inter-sectoral approach that combines health care, social services and housing. There are a number of good examples in Canada of integrating housing within a continuum of care for seniors."[222]**

The Committee heard that non-profit community organizations, religious and cultural groups are increasingly applying for and building various residential facilities for seniors. "Some of them are intergenerational with a variety of health care needs, and they have been quite successful,"[223] as many are able to offer a less expensive alternative to private, personal care homes.

The Royal Canadian Legion told the Committee that it has operated a housing program since the 1980s. The biggest challenge its branches face in launching a new housing project is, "…meeting the mandatory equity requirements to qualify for Canada Mortgage and Housing Corporation insurance. The challenge is because of the more stringent insurance criteria CMHC is imposing for small corporations. This results in increases in the loan-to-equity ratio for small projects. Unfortunately, a small equity gap of $150,000 on a $3 million project could be the only obstacle preventing a project from securing

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221 Canada Mortgage and Housing Corporation, *Supportive Housing for Seniors*, 2000.

222 Robert Dobie, National Advisory Council on Aging, Evidence, November 27, 2006.

223 Douglas Durst, University of Regina, Evidence, November 27, 2006.

construction funding."[224] The Legion proposed the creation of a small revolving fund which would offer gap financing loans with a 5-year deferral on repayment as a potentially self-sustaining tool that would allow smaller residential development projects to get started. An increase in the stock of affordable, supportive housing through projects such as these would ultimately reduce the strain on healthcare and long-term health funding, the Legion suggested.

6.4 Transportation

One of the factors contributing to seniors' well-being, along with health, independence and financial security, is the opportunity to socialize and have meaningful contact with others. Although transportation needs vary with geographic location and health status, transportation options play a key role in giving seniors access to services and activities which can prevent isolation and promote well-being. Transportation issues are particularly significant for seniors in rural and remote communities, where public transit is not as widely available, as well as for the increasing number of seniors living alone, who are at greater risk of isolation.

While almost all seniors have 'theoretical' access to transportation, through their own vehicle, public transit, taxis or the assistance of a friend or family member, the actual level of mobility – the ability to go when and where an individual wants – varies considerably from one individual to another. Data from Statistics Canada's 2005 General Social Survey suggest that many seniors were limited in their social activities because of a lack of access to transportation, and that when access to transportation is inadequate, it can translate into negative consequences for seniors' lives, including a lesser probability of getting out of the house, and a lesser probability of having done volunteer work in the preceding year. Seniors living in rural areas were most likely to have limited access to transportation.[225]

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[224] Jack Frost, Royal Canadian Legion, Evidence, December 11, 2006.

[225] Martin Turcotte, "Seniors' access to transportation" in *Canadian Social Trends*, December 2006, pp.43-50. Statistics Canada Catalogue No. 11-008.

This is despite significant improvements in the number of senior households with a vehicle between 1999 and 2003. The rate increased most substantially for senior women living alone, from 41 per cent to 50 per cent, and for couples, from 84 per cent to 92 per cent.[226]

In 2003, 67 per cent of seniors had a driver's licence (86 per cent of men and 52 per cent of women), a 2 percentage point increase from 2000.[227] The Committee heard that the issue of driving cessation has a large psychological impact on the perception of mobility. "It is interesting that when people come to the point of no longer being able to drive, they see that as the end of being able to be independent and mobile." Some witnesses suggested that there was a need for education of seniors and private sector transportation providers on the availability of services and possible adaptations which might increase the accessibility of taxi services to seniors, such as, "having certain kinds of service on off-peak times, or for set distances that you can go."[228]

The Canadian Association on Gerontology described a system in the United Kingdom whereby a senior can pay gas costs for a neighbour who volunteers to provide transport. It was one example of a variety of models that could serve as examples for Canada.

According to the National Advisory Council on Aging, seniors make up 10 per cent of the national public transit customer base, with the percentage as high as 30 per cent in smaller communities.

6.5 Questions for Further Study

- Does the growing rate of seniors living alone have implications for the type of housing stock that will be required in the future?
- What needs to be done to reduce the incidence of core housing need among Inuit seniors, seniors with disabilities, recent senior immigrants, and the broader Aboriginal senior population?

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226 National Advisory Council on Aging, *Seniors in Canada 2006 Report Card*, 2006, p.42.

227 *Ibid*.

228 Anne Martin-Matthews, Institute of Aging, Evidence, December 11, 2006.

- How much of CHMC funding transferred to the provinces is going towards the creation of affordable housing for seniors?
- Does more need to be done to encourage the use of Flex Housing designs in home construction?
- Could the 'Veterans Independence Program' operated by Veterans Affairs Canada be extended to all Canadian seniors?
- What should Health Canada and Indian and Northern Affairs Canada be doing to improve support services for First Nations seniors on-reserve?
- What are the most effective models for integrating housing within a continuum of care for seniors?
- Beyond addressing the equity requirements for CMHC insurance, what should the government be doing to facilitate the creation of seniors' residential development projects, especially by community groups and small, local developers?
- What are some innovative models for improving seniors' transportation options, especially in rural and remote areas?
- Transportation, housing, and social services are areas of provincial jurisdiction. What role could or should be played by the federal government in these areas?

7. Intergovernmental and Federal Interdepartmental Cooperation and Coordination

The diverse aspects related to seniors (health, income, work, etc.) do not fit neatly within the jurisdiction of any level of government, but cross over the federal, provincial/territorial and municipal levels. Even within the federal level of government, programs for seniors cross several departmental lines. For example, the meeting this Committee held with federal government departments to understand the range of programs provided to seniors brought together eight (8) departments.

This section will provide a summary of the evidence on the range of federal programs and services for seniors; the population groups under federal responsibility; federal interdepartmental co-ordination; the co-

ordination of programs, services and information between jurisdictions; and Canada's role and obligations as part of the 2002 *Madrid Plan of Action on Ageing.*

7.1 Federal Programs and Services for Seniors

> **"Seniors and aging are broad horizontal issues and they are a fundamental part of the federal agenda."**[229]

Aging and seniors issues fall within the mandates of a number of federal departments and agencies. The federal government plays a variety of significant roles in regards to seniors, including the dissemination of information, facilitation of dialogue among other levels of government and with international bodies, and the direct provision of service to a number of population groups. In addition, as the largest employer in Canada, the federal government can play a leadership role in workplace and pension accommodations for senior workers.

At the time of the Committee's hearing, the Committee heard that the Minister of the Department of Human Resources and Social Development Canada was also the Minister for seniors. A Secretary of State for Seniors was appointed in January of 2007.

Some of the key activities of federal government departments in the area of seniors and aging include:

Human Resources and Social Development Canada (HRSDC) is the lead department with respect to seniors' issues within the federal government. Its specific responsibilities include pensions, income support and income security, and the New Horizons for Seniors Program, which provides funding for community-based projects across Canada. HRSDC is also responsible for literacy and lifelong learning and support for older workers, and, through Service Canada, prepares the Guide to Government of Canada Services for Seniors.

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[229] Margaret Gillis, Public Health Agency of Canada, Evidence, December 4, 2006.

Officials informed the Committee that a national cost-shared program with the provinces and territories called the Targeted Initiative for Older Workers had recently been announced to "help unemployed older workers remain active and productive participants in the labour market while their communities undergo adjustment."[230] The Committee also heard that the Department is undertaking "some feasibility work around longer-term approaches towards older workers."[231]

Public Health Agency of Canada – Division of Aging and Seniors deals with health issues related to aging and seniors. The agency currently focuses its resources on four main areas: active aging, emergency preparedness, mental health and falls prevention. It also provides operational support to the National Advisory Council on Aging. The Agency has made efforts to ensure that emergency planning incorporates the needs of seniors. The Committee has heard that "the agency will host an international workshop on emergency preparedness and seniors in Winnipeg in February 2007, with 100 world experts and seniors, to develop a blueprint for action and to influence changes to emergency preparedness policy and practice in order to better integrate seniors' contributions and needs."[232]

In the area of active aging, the Public Health Agency is working with the World Health Organization and other international and domestic partners on a global initiative to foster the development of age-friendly cities that promote active aging and focus on seniors. The Committee heard that "thirty-four cities, including four Canadian cities — Portage la Prairie, Manitoba, Saanich, British Columbia, Sherbrooke, Quebec, and Halifax, Nova Scotia — are participating in this initiative."[233]

Health Canada – First Nations and Inuit Health Branch works with First Nations and Inuit communities in developing home and community care services. In addition, its Non-Insured Health Benefits

230 Peter Hicks, Human Resources and Social Development Canada, Evidence, December 4, 2006.

231 *Ibid*.

232 Margaret Gillis, Public Health Agency of Canada, Evidence, December 4, 2006.

233 *Ibid*.

(NIHB) Program provides coverage for a range of goods and services to First Nations and Inuit persons when these services are not insured elsewhere. Key benefits delivered under the NIHB Program include pharmacy, dental services, vision care, mental health counselling and medical transportation to access health care services that are not available on-reserve or in the community where people live. The pharmacy benefit funds prescription drugs, some over-the-counter medications, as well as medical supplies and equipment, such as wheelchairs and hearing aids.[234]

Health Canada works with First Nations and Inuit communities in developing comprehensive home and community care services to assist people who have chronic and acute illnesses in receiving the care they need in their home or community. Departmental officials told the Committee that, "The First Nations and Inuit Home and Community Care Program experiences similar pressures to those of the provincial and territorial home care programs: increasing complexity of care needs to respond to multiple conditions as the served population ages and, of course, an increasing desire for home-based palliative care."[235]

Indian and Northern Affairs Canada provides an Adult Care Program which assists First Nations people with functional limitations to maintain their independence. It offers in-home supportive care, institutional care, and foster care.

Veterans Affairs Canada provides health care, caregiver support programs, disability pensions and income support for eligible veterans and their survivors. The Department told the Committee that it is in a unique position to consider the needs of and services for an aging population, as the average age of war service veterans is about 82 years of age. As a departmental official told this Committee, "the department has been a pathfinder in terms of programs it offers to an aging population."[236] Veterans Affairs Canada delivers a

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234 Leslie MacLean, Health Canada, First Nations and Inuit Health Branch, Evidence, December 4, 2006.

235 Shelagh Jane Woods, Health Canada, First Nations and Inuit Health Branch, Evidence, December 4, 2006.

236 Bryson Guptill, Veterans Affairs Canada, Evidence, December 4, 2006.

comprehensive home care program (the Veterans Independence Program), a prescription drug program, and a long-term care program. The Department is currently undertaking an extensive and comprehensive health care review with a Gerontological Advisory Council, which is composed of expert gerontologists from all parts of Canada. The witness from Veterans Affairs provided the Committee with some of the preliminary recommendations of this Advisory Council, including the integration all of Veterans Affairs' health care programs into a single program with a common point of entry, and moving towards a needs-based approach rather than one based on entitlement.

The **Canada Mortgage and Housing Corporation** (CMHC) provides research and information on seniors' housing, as well as social housing contributions and renovation programs. The Committee heard that "CMHC is actively involved in research and information transfer activities that address housing challenges for seniors, as well as the possible solutions. This service includes documenting seniors' housing conditions, exploring innovative housing options and providing information to help seniors live safely and independently in their homes and communities."[237]

The **Treasury Board Secretariat** (TBS) supports the Treasury Board in its role as the general manager and employer of the federal public service. This is significant, as the Government of Canada is the largest employer in Canada. In his presentation to the Committee, the witness from the TBS spoke to the impact of the aging population for employees covered under the Public Service Superannuation Act (including employees in the federal public service, Crown corporations, the Canadian Forces and RCMP personnel). According to the Treasury Board Secretariat, "projections and recent experience do not point to a baby boomer exit rush from the federal public service in the immediate future. In fact, based on current trends, we estimate that retirements will increase from present levels, but will do so in a gradual and orderly manner over the next 14 years."[238]

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237 Douglas Stewart, Canada Mortgage and Housing Corporation, Evidence, December 4, 2006.

238 Dan Danagher, Treasury Board Secretariat, Evidence, December 4, 2006.

7.2 Population Groups Under Federal Jurisdiction

Even in areas of jurisdiction which are commonly relegated to the provincial level (including the provision of health services, social services, and labour affairs), the federal government has specific Constitutional responsibility for a number of population groups. The Committee heard evidence related to two of these population groups: Aboriginal people and veterans. The Committee also heard about the role of the federal government as Canada's largest single employer.

The population groups served by the federal government differ dramatically. On the one hand, the Committee has heard that the programs offered by Veterans Affairs to eligible veterans offer a range of services which could serve as a model for seniors programs in Canada. On the other hand, the Committee has heard disturbing testimony about the poor health status and living conditions of many of Aboriginal seniors, and the difficulty many Aboriginal seniors face in accessing services in cities as well as in rural and remote areas. In addition, the Committee heard that "there is a serious lack of good data on Aboriginal people; where they are, what they are accessing, what they are unable to access. Winnipeg is a great example; ten per cent of the population is Aboriginal but we do not know where they are, what they are doing, what they are accessing, what they cannot access."[239] It is important to note that the meetings held by the Committee to date have provided limited opportunities for stakeholders from First Nations and Inuit communities to comment on the adequacy of programs and services provided by the federal government.

7.3 Interdepartmental Collaboration

In the meeting with federal government officials, it was difficult to access how successfully federal government departments were working together to provide cohesive policy-making around aging and seniors issues, and to ensure the seamless delivery of programs and services to seniors.

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[239] Mark Buell, National Aboriginal Health Organization, Evidence, November 27, 2006.

The Committee heard that an interdepartmental committee usually meets three or four times a year, except when all departments are working together on a common project, as they are this year in the preparation of a review of the implementation of the *Madrid Plan of Action on Ageing* in Canada.

Certain departments work together on specific seniors-related initiatives. The Committee heard, for example, that Health Canada and the Department of Indian and Northern Affairs 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 objective of this work in the policy and program framework is to develop a seamless approach to the delivery of care services currently delivered by Health Canada, INAC and in some instances, the province."[240]

Some witnesses suggested that "having a minister involved and dedicated strictly to seniors"[241] would increase the cohesiveness of the federal government's approach to seniors. Other witnesses urged the Committee to carefully consider mixed results in countries which have taken the route of appointing a Minister responsible for seniors.

7.4 Federal / Provincial / Territorial Co-operation

The Committee has heard very little about how jurisdictional divisions of powers impact the range of services available to seniors. It has heard, however, that the Minister of HRSDC chairs a "forum of federal, provincial and territorial ministers with responsibility for seniors, which is currently focusing its work on elder abuse, healthy aging and social isolation."[242] The Public Health Agency is also using this mechanism to work with the provinces and territories to develop

240 Havelin Anand, Indian and Northern Affairs Canada, Evidence, December 4, 2006.

241 Robert Dobie, National Advisory Council on Aging, Evidence, November 27, 2006.

242 Peter Hicks, Human Resources and Social Development Canada, Evidence, December 4, 2006.

an initiative that will "explore the age-friendly city factors in small, rural and remote Canadian communities."[243]

7.5 Impact of Internal Migration on Population Aging

When the working-age population is displaced within the country (either from rural to urban areas, or across regions) to find paid employment, the senior population is often left behind. This results in regional variations in population aging. The Committee has been cautioned to pay close attention to the implications of these regional variations. In his presentation, Dr. Byron Spencer noted that:

> **"The proportion in this so-called "seniors' group," 65 years and over, also varies unevenly across the country. That is one big concern, importantly, because of divided jurisdictions and jurisdictional responsibilities for health care expenditures. As we know, health care is already absorbing large fractions of provincial budgets; so the unevenness of this group matters a great deal."[244]**

As the Committee continues its study, it could examine what, if any, role the federal government could play to address the uneven impact of population aging across the country.

7.6 Madrid International Plan of Action on Ageing,[245] 2002

The United Nations Second World Assembly on Ageing was held in Madrid in 2002 and resulted in the development of the *International Plan of Action on Ageing, 2002*. Canada played an important role in the development of the Plan and was one of almost 190 countries to sign. The *International Plan of Action on Ageing, 2002* is meant to be a call to action for changes in attitudes, policy and practices to ensure that persons everywhere are able to age with security and dignity as

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243 Margaret Gillis, Public Health Agency of Canada, Evidence, December 4, 2006.

244 Byron Spencer, McMaster University, Evidence, November 27, 2006.

245 The United Nations uses the spelling "Ageing".

full participants in society. The recommendations in the Plan are organized according to three priority areas for action: older persons and development; advancing health and well-being into old-age; and ensuring enabling and supportive environments.

Witnesses raised the *International Plan of Action on Ageing, 2002* as an important policy tool in developing programs and policies which ensure the full participation of seniors in our society.

> **"Is it time to consider using this plan as a framework for the future: An important national planning tool that addresses inequities across the provinces and creates the vehicle for social change where older persons will know intuitively that they are one of the keys to healthy and vibrant communities?"**[246]

The Plan called for global monitoring, review, and updating. Witnesses before the Committee indicated that Human Resources and Social Development Canada was currently working, in collaboration with other federal departments, on the development of a report of Canada's progress under the *International Plan of Action on Ageing, 2002.*

> **"Countries have been asked to voluntarily review their progress made. Currently, we are assembling different departments and it is helpful to have you on this committee to know where we stand in terms of the progress made. We are making a decision to go forward, to report on progress and to listen to other countries to learn of measures taken abroad so that we are better informed. I believe that in February or March we will report to the United Nations."**[247]

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

247 Marla Israel, Human Resources and Social Development Canada, Evidence, December 4, 2006.

7.7 Questions for Further Study

- Should or could the federal government play a role in mediating the potentially uneven impact of health-related costs associated with the uneven distribution of older seniors among the provinces and territories? If so, how?
- How does the federal government coordinate its efforts with the provinces and territories in areas of shared jurisdiction?
- How well is the federal government providing for seniors for which it has jurisdictional responsibility, such as veterans, First Nations on reserve and the Inuit?
- Is there a role for the federal government in setting national standards in areas such long-term care, as has been proposed by several witnesses?
- How accessible is information about the Government of Canada's programs and services for seniors? Are communication tools being used by the federal government appropriate to the current cohorts of seniors?

Witness List

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.

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.

Health Canada, First Nations and Inuit Health Branch
Leslie MacLean, Director General, Non-Insured Health Benefits;
Shelagh Jane Woods, Director General, Primary Health Care and Public Health Directorate.

Indian and Northern Affairs Canada
Havelin Anand, Director General, Social Policy and Programs Branch.

Veterans Affairs Canada
Bryson Guptill, Director General, Program and Service Policy Division

Canada Mortgage and Housing Corporation
Douglas Stewart, Vice President, Policy and Planning.

Treasury Board of Canada Secretariat
Dan Danagher, Executive Director, Labour Relations and Compensation Operations.

Public Service Human Resources Management Agency of Canada
Cecilia Muir, Director General, Public Service Renewal and Diversity.

December 11, 2006

CARP – Canadian Association for the Fifty-plus
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.