AN EVIDENCE-INFORMED NATIONAL SENIORS STRATEGY FOR CANADA

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ALLIANCE FOR A
NATIONAL SENIORS STRATEGY

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This report sets the agenda for the inaugural activities of the National Institute of Ageing (NIA) being established at Ryerson University.

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Why Does Canada Need a National Seniors Strategy?

NATIONAL SENIORS STRATEGY

INDEPENDENT, PRODUCTIVE & ENGAGED CITIZENS

Enables older Canadians to remain independent, productive and engaged members of our communities.

HEALTHY AND ACTIVE LIVES

Supports Canadians to lead healthy and active lives for as long as possible.

CARE CLOSER TO HOME

Provides person-centered, high quality, integrated care as close to home as possible by providers who have the knowledge and skills to care for them.

SUPPORT FOR CAREGIVERS

Acknowledges and support the family and friends of older Canadians who provide unpaid care for their loved ones.

THE FOUR PILLARS SUPPORTING A NATIONAL SENIORS STRATEGY

ACCESS | EQUITY | CHOICE | VALUE | QUALITY

THE FIVE FUNDAMENTAL PRINCIPLES UNDERLYING A NATIONAL SENIORS STRATEGY

WHY DOES CANADA NEED A NATIONAL SENIORS STRATEGY?

We have reached an interesting time in our history with 2015 marking the first year Canadians aged 65 and over outnumbered those who are younger than 15 years of age.[1] Older Canadians now represent the fastest growing segment of our population – their numbers will double over the next two decades and by 2035, one in four Canadians will be older than 65 years of age. This unprecedented demographic shift will clearly present us with both challenges and opportunities but our national coming of age should be seen as a triumph rather than a pending disaster.

The ageing of our population is not unique but rather reflects a rapidly accelerating worldwide trend. The World Health Organization's (WHO) recently released inaugural *World Report on Ageing and Health*[2], recommends responding to the coming challenges and opportunities expected with population ageing with equally profound changes to the ways policies and services for ageing populations are formulated and provided. Indeed, the WHO asserts that with the right policies and services in place, population ageing should be viewed as a rich new opportunity for both individuals and societies.

A NATIONAL SENIORS STRATEGY WILL REQUIRE FEDERAL LEADERSHIP

Meeting the growing and evolving needs of Canada's ageing population will require concerted coordination and effort between municipal, provincial and territorial governments, with the federal government playing a key leadership role.

Historically, our federal government has been able to play a key role as a standard-setter, catalyst and funder of important social change in areas such as low-income support, housing and national health insurance. We believe that in a similar way, our federal government can and should enable the meaningful change that will be needed to meet the needs of ageing Canadians.

The way we approach our coming of age will also require coordination and mobilization across all levels of government as well as between the private and public sectors. Indeed, we will need an integrated approach where the federal government helps keep us all moving in the right direction. It is clear that Canadians of all ages want to ensure that our country will value and support the growing number of older Canadians. The Federal government should recognize that shared aspiration and create and deliver on a National Seniors Strategy.

This report identifies key issues that our country faces and outlines the pillars that can support a National Seniors Strategy for Canada. Using an evidence-based process, our Canadian Institutes of Health Research (CIHR) funded team supported by the Canadian Alliance for a National Seniors Strategy, identified 12 specific policy issues of national importance under four overarching pillars or themes that should be addressed with federal leadership to meet the current and future needs of Canada's ageing population.

This recent federal election was the first where Canada's ageing population became a prominent and consistent theme in party platforms and in the debates between our political parties. Our newly elected government has committed to addressing pension reform, improving the delivery of home care services, access to necessary medications and addressing the needs of older Canadians as an overall priority. It is our hope that this evidence-based report will help inform and guide the important conversations and policy exercises that will need to occur in the coming years.

OUR PROCESS TOWARDS THE DEVELOPMENT OF AN EVIDENCE-INFORMED NATIONAL SENIORS STRATEGY

The concept of a National Seniors Strategy has been discussed at a policy and political level over the past few years, and ensuring that the dialogue could progress as evidence-based and informed conversation is equally called for. With this in mind, we applied for funding under the CIHR – Evidence-Informed Healthcare Renewal (EIHR) Initiative and were subsequently funded through that initiative with the support of the Institute for Health Services and Policy Research and the Institute for Aging. More about the research team behind this report can be found at the end of this report.

Our team started its efforts in 2013 by conducting a jurisdictional review – in collaboration with the European Observatory on Health Systems and Policies – of the evidence on strategies, approaches, and practices employed towards meeting the needs of an aging population. Sources included published and unpublished reports, policy briefs, data, and analyses from Canada and beyond; with focus on jurisdictions demonstrating leadership in these areas of focus. Our team further consulted broadly with a wide range of stakeholders over a 12-month period to inform the overall findings that would support the evidence-informed policy recommendations that this report lays out. The work of developing an evidence-informed National Seniors Strategy has become a collaborative opportunity to build upon the expert work of others. The main national organizations that offered advice and support and their eventual endorsement for this overall body of work are also acknowledged at the end of this report. These organizations in particular broadly represent a growing group now being increasingly recognized across Canada as the *Alliance for a National Seniors Strategy.*

In developing our report on what a National Seniors Strategy for Canada should entail, we adopted an evidence-based process and framework that our team used to identify and address twelve specific policy issues that were identified under four overarching pillars or themes; and supported by five core principles essential to understanding the needs of Canada's ageing population. Our work was and continues to be iterative and has been released, updated and re-released publically through our website **www.nationalseniorsstrategy.ca** in evolving versions. Our intention is to allow this work to continuously evolve until the issues we highlight are fully resolved. We are proud that this work will now become the basis for the activities of the new National Institute of Ageing (NIA) being established at Ryerson University in early 2016.

Our overarching goal of this work will be to continue an evidence-based dialogue on a National Senior Strategy. One example of our work's influence to date was the use of our four overarching pillars or themes as the basis of the Institute for Research on Public Policy's (IRPP) recently released and critically acclaimed report entitled *Designing a National Seniors Strategy for Canada*.[3] We hope our work will reach a broad community of stakeholders and citizens through media dialogue on ageing, our website and social media campaign. We encourage you to join the conversation at @NSS_Now.

As mentioned above, the World Health Organization (WHO) recently released their inaugural *World Report on Ageing and Health*.[4] This reports outlines a clear call to action for member states to meet the evolving needs of their ageing populations through well designed and formulated policies and services. The WHO is now engaged in a process to mobilize member states, including Canada, to agree to five priority areas for action by 2020 which include:

1. Fostering healthy ageing in every country
2. Aligning health systems to the needs of older populations
3. Developing long-term care systems
4. Creating age-friendly environments
5. Improving, measuring, monitoring and understanding

The principles, pillars and 12 specific policy issues of focus we have identified in our work not only resonate with Canadians, but will also enable Canada to address the WHO's five priority areas for action. We hope that this report and the evidence briefs that support its recommendations will continue to evolve over the coming years. Ultimately our shared goal is to create a future that gives older Canadians the support and freedom to live their lives to the fullest.

INTRODUCING THE FOUR PILLARS AND FIVE FUNDAMENTAL PRINCIPLES SUPPORTING A NATIONAL SENIORS STRATEGY FOR CANADA

NATIONAL SENIORS STRATEGY

INDEPENDENT, PRODUCTIVE & ENGAGED CITIZENS

Enables older Canadians to remain independent, productive and engaged members of our communities.

HEALTHY AND ACTIVE LIVES

Supports Canadians to lead healthy and active lives for as long as possible.

CARE CLOSER TO HOME

Provides person-centered, high quality, integrated care as close to home as possible by providers who have the knowledge and skills to care for them.

SUPPORT FOR CAREGIVERS

Acknowledges and support the family and friends of older Canadians who provide unpaid care for their loved ones.

THE FOUR PILLARS SUPPORTING A NATIONAL SENIORS STRATEGY

ACCESS	EQUITY	CHOICE	VALUE	QUALITY

THE FIVE FUNDAMENTAL PRINCIPLES UNDERLYING A NATIONAL SENIORS STRATEGY

PILLAR 1: INDEPENDENT, PRODUCTIVE AND ENGAGED CITIZENS

ENSURING OLDER CANADIANS REMAIN INDEPENDENT, PRODUCTIVE AND ENGAGED CITIZENS

With the number of older Canadians expected to double over the next two decades, with many more living most of their extra years in good health, we need to ensure older Canadians are given the opportunities to remain engaged and productive members of our society. Since we ended mandatory retirement laws in Canada, the number of older Canadians who continue to work past the age 65 has doubled over the past decade, allowing them to continue contributing their considerable experience and skills. Importantly, paid work is only part of older Canadians' contributions.

Older Canadians continue to contribute to our society in many other ways and over represent themselves as volunteers, and unpaid caregivers to Canadians of all ages. They are also the most politically engaged members of our society. Ensuring our communities can continue to support their older residents to remain independent and engaged, will mean a need to continue to strengthen access to a reasonable income, affordable housing and transportation services. To combat the growing levels of social isolation and reinforce efforts to end ageism and elder abuse in our society, our physical environments and public spaces need to be age-friendly; and our community, social and recreational services must be designed with the needs of older Canadians in mind.

The Federal Government can work with Canada's provinces, territories and municipalities to enable this pillar in a variety of ways.

- **Making Addressing Ageism, Elder Abuse and Social Isolation a National Priority**

  Ensuring that we make addressing ageism, elder abuse and social isolation a national priority by continuing to support activities and policies that value the role, contributions and needs of older Canadians such as supporting volunteerism and other forms of community engagement. Read more on this opportunity in Evidence Brief #1.

- **Ensuring Older Canadians do not Live in Poverty by Improving their Income Security**

  Ensuring older Canadians don't live in poverty can be achieved by making enhancements to the current Canadian Pension Plan and other mechanisms that promote greater income security. Read more on this opportunity in Evidence Brief #2.

- **Ensuring Older Canadians have Access to Affordable Housing and Transportation Options**

  Ensuring a growing proportion of federal infrastructure dollars support the development of more affordable housing and transportation options that will allow older Canadians to remain more independent in their communities. Read more on this opportunity in Evidence Brief #3.

- **Enabling the Creation of Age-Friendly Physical Environments and Spaces**

  Ensuring the development of more age-friendly physical environments and spaces through the incorporation of well-established universal design standards in our national building codes. Read more on this opportunity in Evidence Brief #4.

PILLAR 2: HEALTHY AND ACTIVE LIVES

ENSURING OLDER CANADIANS CONTINUE TO LEAD HEALTHY AND ACTIVE LIVES FOR AS LONG AS POSSIBLE

Important advances in public health and health care over the last few decades mean that most Canadians are now living longer and with fewer health problems than ever before. In the future we need to do more to educate and support Canadians to participate in activities that promote wellness, prevention and overall healthy ageing so that more older Canadians can age in good health and stay independent in their communities for as long as possible.

The Federal Government and the Public Health Agency of Canada can work with Canada's provinces, territories and municipalities to enable this pillar and associated activities in a variety of ways.

- **Ensuring Canadians are Supported to Engage in Wellness and Prevention Activities that Enable Healthy Ageing**

  Ensuring Canadians understand the importance of activities that support healthy ageing and the prevention of age-related diseases and are empowered and supported to regularly exercise, develop strategies for falls prevention, and get recommended vaccines. Read more on this opportunity in Evidence Brief #5.

- **Improving Access to Medically Necessary and Appropriate Medications**

  Ensuring that all Canadians have access to medically necessary and appropriate medications for the management of acute and chronic diseases will allow Canadians to live healthier and longer lives in their communities. Read more on this opportunity in Evidence Brief #6.

- **Ensuring Older Canadians and their Caregivers are Enabled to Participate in Informed Health Decision-Making & Advance Care Planning**

  Ensuring Canadians have a better understanding of the importance of advance care planning will support Canadians to become more engaged in decision-making around their health care and empower them to make more informed decisions. Read more on this opportunity in Evidence Brief #7.

PILLAR 3: CARE CLOSER TO HOME

ENSURING OLDER CANADIANS HAVE ACCESS TO PERSON-CENTERED, HIGH QUALITY, AND INTEGRATED CARE AS CLOSE TO HOME AS POSSIBLE BY PROVIDERS WHO HAVE THE KNOWLEDGE AND SKILLS TO CARE FOR THEM

Currently older Canadians constitute about 16% of our population, but account for nearly half of our health and social care systems costs. Medicare, our national health insurance system for doctors and hospitals, was established over 50 years ago when the average age of a Canadian was 27 and when most Canadians didn't live beyond their 60s. Our population has changed yet our health care system has not fully adapted to meeting the needs of an ageing population. The majority of Canadians now see access to supportive and palliative care in or close to their homes, and a robust home care system, as top national priorities. We now need to focus on strengthening our Canada Health Act and the Canadian Health Transfer to ensure Canadians can feel confident that our health care system will be ready to meet their needs.

To ensure current and future providers will have the knowledge and skills needed to provide Canadians the right care, in the right place, at the right time by the right provider, our national educational and accreditation bodies for all caring professions including doctors, nurses, social workers should mandate training around the care of the elderly in the same was as they do for other age groups such as children.

The Federal Government and the Federal Ministry of Health can work with Canada's provinces, territories to enable this pillar of activities in a variety of ways.

- **Ensuring Older Canadians have Access to Appropriate, High Quality Home and Community Care, Long-Term Care, Palliative and End-of-Life Services**

  Ensuring older Canadians have access to high quality home and community care, long-term care, palliative and end-of life services as well as medications when and wherever needed, can become a focus and priority of a new Canada Health Transfer, that ties increases in federal support to expected performance improvements. Read more on this opportunity in Evidence Brief #8.

- **Ensuring Older Canadians have Access to Care Providers that are Trained to Specifically Provide the Care they Need**

  Ensuring that Canadians have access to care providers from all professions that are trained to specifically provide the care older Canadians will need, in a culturally sensitive way, is an area that our national educational and care accreditation bodies can be encouraged to prioritize. Read more on this opportunity in Evidence Brief #9.

- **Developing Standardized Metrics and Accountability Standards to Enable a National Seniors Strategy**

  Ensuring that we stay on track in retooling our health care systems to meet the needs of an ageing population will require that Canadians, along with our health system funders and planners, have access to high quality information that can help us track our performance in meeting our collective goals. Establishing national metrics, information collection and reporting systems through agencies like the Canadian Institutes for Health Information (CIHI), can allow us to link funding to performance and better support all areas of the nation in meeting our collective goals. Read more on this opportunity in Evidence Brief #10.

PILLAR 4: SUPPORT FOR CAREGIVERS

ENSURING THAT THE FAMILY AND FRIENDS OF OLDER CANADIANS WHO PROVIDE UNPAID CARE FOR THEIR LOVED ONES ARE ACKNOWLEDGED AND SUPPORTED

In Canada, family and friends are the greatest source of care for older people. As the number of older Canadians with chronic health conditions including dementia increases, more of us will need the support of caregivers. Last year it was estimated that unpaid caregivers provided care that would have cost our system around $30B. The continued dedication and contribution of caregivers sustains our ability to care for older people in the health care system. However, caregivers face an enormous toll on their own health and well-being and their commitment to caregiving has an impact on Canada's economic productivity. Providing appropriate support and recognition to meet the needs of current and future caregivers will not only keep our health care systems sustainable, but will also ensure that our economic productivity as a nation can be improved and strengthened.

The Federal Government can work with Canada's provinces, territories to enable this pillar and associated activities in a variety of ways.

- **Ensuring Older Canadians are Supported in the Workplace**

  Ensuring Canadian employers are informed about and have access to the tools that can help them better support the growing ranks of working caregivers will enhance our overall economic productivity. Recognizing employers who excel in supporting working caregivers can further bring positive attention to this important issue. Read more on this opportunity in Evidence Brief #11.

- **Ensuring Caregivers are Not Unnecessarily Financially Penalized for Taking on Caregiving Roles**

  Ensuring Canadians caregivers are not unnecessarily financially penalized for taking on caregiving roles can be further supported through enhanced job protection measures, caregiver tax credits and enhanced CPP contribution allowances that all have good evidence to support their broad implementation nationally. Read more on this opportunity in Evidence Brief #12.

THE FIVE PRINCIPLES SUPPORTING A NATIONAL SENIORS STRATEGY

As work moves forward to create a National Seniors Strategy that helps to build a nation that values, encourages and promotes the wellness and independence of older Canadians, it will be vital to ensure that any proposed policies, programs, and services adhere to the five foundational principles that Canadians and the organizations representing them told us mattered most to them.

These five principles were originally derived through the creation of the Ontario Seniors Strategy and its consultations with thousands of Ontarians, as well as national and international experts and stakeholders. We were pleased to see that these same foundational principles continue to resonate with the broader national audience that is now fully engaged in this work.

ACCESS

We are spending more on health, social, and community services than ever before, yet older Canadians, their families, and their caregivers still find it challenging to access the right care and supports, in the right place, at the right time – especially for those living in rural and remote communities and those with more limited financial means. Therefore, when planning, reviewing, and delivering services we need to ask ourselves whether we are ensuring that older Canadians, their families, and their caregivers can easily access the services and supports they need in a timely and efficient way.

EQUITY

We recognize that one of our greatest assets as a nation is our diversity. Given that diversity is both visible and invisible, we need to ensure that the needs of older Canadians from different ethnocultural groups are acknowledged as well as those from our lesbian, gay, bisexual, transsexual and queer (LGBTQ) communities, those whose abilities are limited and those with special needs, such as the homebound, are equally supported. Therefore, when planning, reviewing, and delivering services, we need to ask ourselves whether we are ensuring, where possible, that older Canadians from diverse backgrounds are having their needs met in a way that acknowledges their sociocultural circumstances.

CHOICE

We offer an incredible variety of supports and services for older Canadians, yet their ability to understand their options and express their choices is not always as fully realized as it should be. Older Canadians have the right to know what their options are and, when capable, make informed decisions with which they are comfortable. We never question a younger adult's right to make good or poor decisions, so we also need to appreciate and acknowledge that older Canadians should still be supported even if they make informed decisions that allow them to live at risk. Therefore, when planning, reviewing, and delivering services to them, we need to ask ourselves whether we are ensuring that older Canadians, their families, and their caregivers have as many choices as is reasonable and possible, and whether they are also supported and empowered with the best information to make informed choices.

VALUE

With our current and future fiscal and demographic imperatives, we need to ensure we are spending our tax dollars in the most effective and efficient ways to help ensure the future sustainability of our systems, programs, and services. Therefore, when planning, reviewing, and delivering services, we need to ask ourselves whether we are ensuring that every dollar we spend is providing the best value possible.

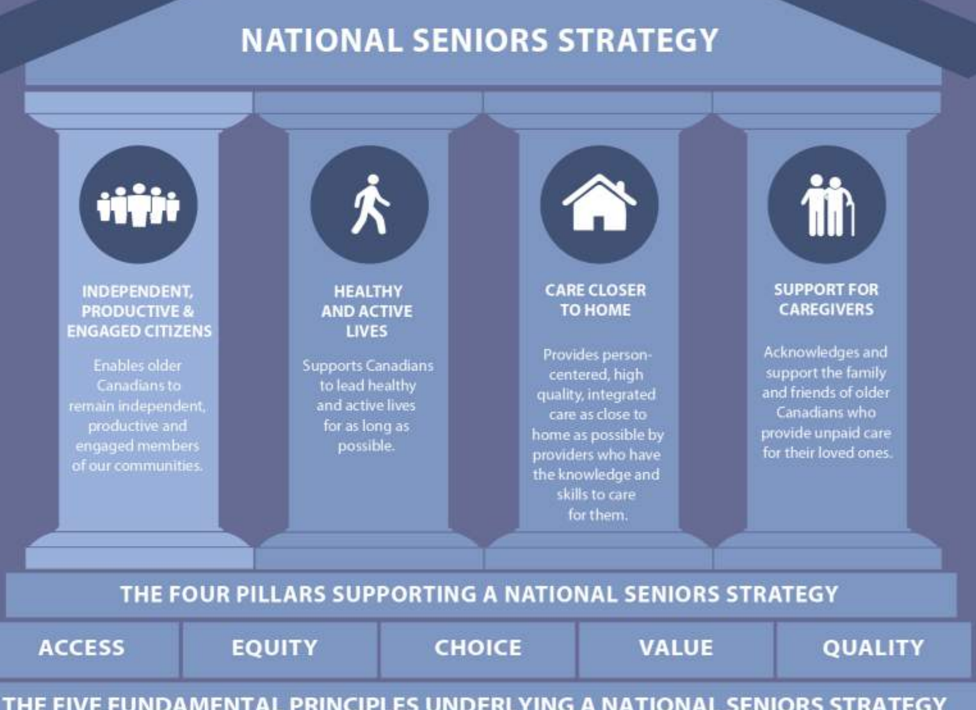
QUALITY

Within our mandate to control current and future costs, we need to ensure that we never do this at the cost of quality. We are increasingly understanding that better quality care in many cases doesn't actually cost more; it will not only meet our expectations, but also deliver desired outcomes that governments, service providers, and the public all value. Therefore, when planning, reviewing, and delivering services, we need to ask ourselves whether we are ensuring that a focus on quality is central to the work at hand.

SECTION 1

THE FIRST PILLAR

Independent, Productive and Engaged Citizens



PILLAR 1: INDEPENDENT, PRODUCTIVE AND ENGAGED CITIZENS

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Older Canadians continue to contribute to our society in many other ways and over represent themselves as volunteers, and unpaid caregivers to Canadians of all ages. They are also the most politically engaged members of our society. Ensuring our communities can continue to support their older residents to remain independent and engaged, will mean a need to continue to strengthen access to a reasonable income, affordable housing and transportation services. To combat the growing levels of social isolation and reinforce efforts to end ageism and elder abuse in our society, our physical environments and public spaces need to be age-friendly; and our community, social and recreational services must be designed with the needs of older Canadians in mind.

The Federal Government can work with Canada's provinces, territories and municipalities to enable this pillar in a variety of ways.

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  Ensuring that we make addressing ageism, elder abuse and social isolation a national priority by continuing to support activities and policies that value the role, contributions and needs of older Canadians such as supporting volunteerism and other forms of community engagement. Read more on this opportunity in Evidence Brief #1.

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Evidence-Informed Policy Brief # 1

Making Addressing Ageism, Elder Abuse and Social Isolation a National Priority

National Seniors Strategy Evidence Informed Policy Brief # 1

Making Addressing Ageism, Elder Abuse and Social Isolation a National Priority

Setting the Context:

Older Canadians are valuable members of our communities, yet many are vulnerable to various forms of ageism, abuse, mistreatment and isolation from the same communities that also value them. Ageism is commonly understood to be, "the stereotyping of, and discrimination against, individuals or groups because of their age".[5] While this can include those who are young or old, ageism appears to be a more significant issue for older members of our society. Indeed, many have come to remark how this form of discrimination still appears to be the last acceptable 'ism' in our society.

Ageism is multi-faceted and manifests itself in multiple ways, such as prejudicial attitudes towards older people, old age, and the ageing process; discriminatory practices against older people; and institutional practices and policies that perpetuate stereotypes about older people.[6,7] While there has been work undertaken in Canada and internationally to address ageism, it still remains a significant problem. In a recent Canadian survey on ageism, **63%** of respondents 66 years of age and older indicated that, "they have been treated unfairly or differently because of their age".[8] Comparatively, **80%** of Canadians agree with the statement, "older adults 75 and older are seen as less important and are more often ignored than younger generations"; while **51%** agree that, "ageism is the most tolerated social prejudice when compared to gender or race-based discrimination".[9] That the vast majority of participants expressed these views on ageing should be a cause for concern.

Negative attitudes regarding older Canadians can have a significant impact on their health, well-being, and involvement within our communities. Indeed, ageism can influence the way we make decisions about others based on age-related biases. We see ageism play out all the time within areas such as health care when we let a person's age, rather than their overall status, influence our decisions to conduct a test or provide a treatment. We see it again in the workforce where we may let a person's age, rather than their experience and abilities, influence a hiring decision. Mandatory retirement was ended in Canada in December 2006 when the federal government officially repealed the section of the Canadian Human Rights Act that permitted mandatory retirement. Nevertheless, according to a recent poll, 74 % of Canadians still consider age discrimination to be a problem in the workplace.[10] Finally, when we fail to recognize that older persons may have special needs that we should accommodate accordingly, it raises concerns that we may not value this population in our society as much as we should.

Below we provide an overview of two specific consequences often linked to ageism: elder abuse and social isolation.

Elder Abuse

The World Health Organization defines the abuse of older adults as, "a single or repeated act, or lack of appropriate action, occurring in any relationship where there is an expectation of trust that causes harm or distress to an older person."[11] Elder abuse can destroy an older person's quality of life, and significantly increase their overall risk of death. Elder abuse can take several forms, including physical abuse, psychological or emotional abuse, financial abuse, sexual abuse, and neglect. Table 1 provides a description of the different forms of elder abuse.

Table 1. Understanding the Several Forms of Elder Abuse[12]

Form	Description
Financial Abuse	The most common form of elder abuse, financial abuse, often refers to the theft or misuse of money or property like household goods, clothes or jewelry. It can also include withholding funds and/or fraud.
Psychological (Emotional) Abuse	The wilful infliction of mental anguish or the provocation of fear of violence or isolation is known as psychological or emotional abuse. This kind of abuse diminishes the identity, dignity and self-worth of the senior. Forms of psychological abuse include a number of behaviours, for example: name-calling, yelling, ignoring the person, scolding, shouting, insults, threats, provoking fear, intimidation or humiliation, infantalization, emotional deprivation, isolation or the removal of decision-making power.
Physical Abuse	Any physical pain or injury that is wilfully inflicted upon a person or unreasonable confinement or punishment, resulting in physical harm, is abuse. Physical abuse includes: hitting, slapping, pinching, pushing, burning, pulling hair, shaking, physical restraint, physical coercion, forced feeding or withholding physical necessities.
Sexual Abuse	Sexual abuse is understood as contact resulting from threats or force or the inability of a person to give consent. It includes, but is not limited to: assault, rape, sexual harassment, intercourse without consent, fondling a confused older adult, intimately touching an older adult during bathing, exposing oneself to others, inappropriate sexual comments or any sexual activity that occurs when one or both parties cannot, or do not, consent.
Neglect	Neglect can be intentional (active) or unintentional (passive) and occurs when a person who has care or custody of a dependent senior fails to meet his/her needs. Forms of neglect include: withholding or inadequate provision of physical requirements, such as food, housing, medicine, clothing or physical aids; inadequate hygiene; inadequate supervision/safety precautions; withholding medical services, including medication; overmedicating; allowing a senior to live in unsanitary or poorly heated conditions; denying access to necessary services (e.g., homemaking, nursing, social work, etc.) or denial of a older adult's basic rights. For a variety of reasons, older adults themselves may fail to provide adequate care for their own needs and this form of abuse is called self-neglect.
Systemic Abuse	Our society, and the systems that develop within it, can generate, permit or perpetuate elder abuse. Most prevalent is discrimination against older adults, due to their age and often combined with any of these additional factors: gender, race, colour, language, ethnic background, religion, sexual orientation, ability, economic status or geographic location.

Understanding the prevalence and severity of elder abuse is difficult to ascertain since, in many instances, abuses are often underreported or go unnoticed. This is due largely in part to many older persons unwillingness to report elder abuse because of the social stigma attached to it or because of their concern regarding the consequences of reporting a loved one or caregiver. For instance, reporting abuse could mean the withdrawal of care or the loss of their caregiver, making their decision to report abuse much more difficult. As a result, while up to **10% of older Canadians experience a form of abuse**[13], it's estimated that "only **one in five** incidents of elder abuse are reported".[14]

In 2013, up to 500,000 older Canadians may have experienced a form of abuse - Statistics Canada also estimated that approximately **8,900 older Canadians were also the victims of a violent crime.**[15] While older adults are the least likely demographic to suffer violent crime, they are the population most at risk of suffering violence at the hand of a family member or relative[16], and police-reported violence against older adults appears to be on the rise. Other and more hidden and common forms of elder abuse are also on the rise. For example, likely related to the recent economic downturn, large Canadians law firms report seeing a striking increase in the number of challenges to Power of Attorney and other abuse related claims – but most commonly those related to financial abuse.[17] Health Canada notes that financial abuse of older adults tends to be the most common form of abuse (62.5 %), followed by verbal (35 %) and physical abuse (12.5 %), along with neglect (10 %).[18] Primary caregiver stress has also been shown to significantly contribute to the incidence of elder abuse, highlighting the need to provide unpaid caregivers with increased supports.

Elder abuse is also more complicated than abuse in other age categories – such as child abuse – since older adults tend to be capable of addressing issues themselves. However, the power imbalances that can occur in relationships between older adults and their families or caregivers, especially if the former is dependent on the latter for having one's living or care needs met, further complicates these situations. The increasing prevalence of older Canadians living with dementia, functional impairments, or poverty, is placing older adults in vulnerable positions that could allow them to become victims of abuse or neglect. Furthermore, determining when health, social and community care, and public safety professionals have a duty to report elder abuse and neglect (as we do with child abuse and neglect) is another aspect that will need to be revisited. Older adults may neglect to take care of their personal health and well-being, often due to declining mental awareness or capability. Some older adults may also choose to deny themselves health or safety benefits, which may not be self-neglect, but a reflection of their personal choice. While difficult, caregivers and other responsible parties must honour an older person's choice to live at risk, especially if the older adult is capable of making such a choice. There is a need to keep in mind our own biases that often conflict with a person's right to make decisions, particularly when those decisions do not comply with conventional recommendations.

As Canada's population ages, the potential exists that elder abuse will increase unless it is more comprehensively recognized and addressed. At a minimum, we will need to do better as a nation at raising awareness among older Canadians and members of the public about elder abuse and neglect so they can understand when and how they should provide help.

Social Isolation

Older Canadians are particularly at risk of becoming socially isolated. We have become a society less likely to live in intergenerational households and communities, and less likely to participate regularly in traditional faith-based or social groups. Furthermore, the growing presence of physical and cognitive limitations as we age, along with the fact that older adults also tend to outlive their decision to stop driving by up to decade, may all contribute to further limiting one's ability and or willingness to interact with others.

The increased social frailty that can develop with time as a result of the above can put older Canadians at particular risk of becoming socially isolated – especially when outliving their spouses or partners, family members, or friends. A report focusing on ageing in rural and remote areas of Canada noted that social isolation can be caused by having a lack of transportation options, amongst other factors.[19] The latest Canadian Healthy Aging Survey noted that 27% of its older Ontarian respondents, for example, reported they were not socially connected with others, while 17% reported feeling isolated.[20] We know that social isolation can have a significant effect on a person's overall health and well-being, and therefore finding ways to minimize this in our communities should remain a priority.

A National Seniors Council Report on the Social Isolation of Seniors (2014)[21] determined that older Canadians are at increased risk for social isolation when:

- Living alone;
- Being age 80 or older;
- Having compromised health status, including having multiple chronic health problems;
- Having no children or contact with family;
- Lacking access to transportation;
- Living with low income;
- Changing family structures, younger people migrating for work and leaving seniors behind, and location of residence (e.g. urban, rural and remote); and
- Critical life transitions (e.g. retirement).

Social isolation is considered both a risk factor for as well as a result of elder abuse, representing the complexity and importance of the social network around the health and well-being of older Canadians.[22] Though rates of social isolation are not widely available, reasonable estimates report that up to **20% of older adults currently experiencing some degree of social isolation**[23] – a phenomenon likely to increase significantly with our evolving demographics and changing social community norms toward independent living. While the negative effects of isolation are primarily borne by older adults themselves, our communities are at risk of suffering from the lack of involvement of our valued older community members as well. Missing the contributions of older adults can lead to, "a lack of social cohesion, higher social costs, and the loss of an unquantifiable wealth of experience that older adults bring to our families, neighbourhoods and communities". [24]

Finally, concerted efforts on behalf of the Canadian government have been made to raise awareness around and address issues of elder abuse and social isolation in our country. Some key initiatives have included:

- *Launching of the* ***Elder Abuse - It's Time to Face the Reality*** Awareness Campaign on television, print and online in 2009 followed by a public opinion survey that showed 91% of Canadians have a basic awareness of elder abuse.[25]
- Passage of the ***Protecting Canada's Seniors Act*** in 2013 which amended the Criminal Code of Canada so that age is considered an aggravating factor for criminal sentencing purposes.
- Adoption of the ***Canadian Victims Bill of Rights*** in 2014 that gives statutory rights to victims of crime.
- Launching of the ***Government of Canada's www.seniors.gc.ca*** website in 2015 as online awareness and resource centre that includes specific sections on elder abuse and social isolation.

What Are the Issues?

1. Age-Related Social Issues such as Ageism, Elder Abuse, and Social Isolation Pose Significant Negative Health Risks for Older Canadians

Ageism, Elder Abuse, and Social Isolation in all of its forms, negatively impacts the health of older adults. While some forms of elder abuse, including physical or sexual abuse, in particular have more obvious negative health implications[26], other forms of elder abuse such as financial abuse have the potential to deprive older adults of basic necessities for health and wellbeing. Additionally, ageist stereotypes based on perpetuated myths regarding the abilities and competencies of older adults affect their ability to remain active and valued members of society. Similarly, social isolation – whether it is self-imposed or imposed by others – is also known to have tangible and significant effects on the health status of older Canadians.

In a meta-analysis of 148 studies, authors demonstrated that social isolation is a significant predictor of death.[27] Further, as a predictor of early mortality, social isolation was as strong a predictor as smoking over 15 cigarettes a day or excessively consuming alcohol.[28] Social isolation has been proven to lead to engagement in adverse health behaviours such as: smoking, drinking and maintaining an unhealthy diet.[29] This may help explain why isolated older adults are more likely to experience a fall, coronary heart disease, stroke, suicide and depression.[30,31] Evidence further suggests that social isolation is a correlate of specific illnesses such as dementia. Specifically, "the lack of supportive social networks has been linked to a **60% increase in the risk of dementia and cognitive decline."**[32] Importantly, social inclusion is a significantly protective factor against death and dementia.[33,34]

2. Elder Abuse and Social Isolation have Systemic Cost Implications

The impact of social isolation and elder abuse on the individual health status of older Canadians also directly results in broader health and social system costs. For example, social isolation has been shown to be a significant risk factor for hospitalization[35] and hospital re-admission[36] amongst older adults. In fact, socially isolated older adults are four to five times more likely to be admitted to hospital than older adults in general.[37] Disease specific costs known to be correlated to social isolation, such as heart disease, stroke, dementia and depression as well as falls are themselves significant. Finally, social isolation has been identified as one of the top four predictors for placement into long-term care settings.[38]

3. Certain Populations are More Vulnerable to Experiencing Social Isolation and Elder Abuse

Current evidence suggests that there are specific older populations of Canadians that are particularly at risk of experiencing social isolation and elder abuse. The National Seniors Council Report on the Social Isolation of Seniors (2014)[39] highlighted the following specific populations as being at greatest risk:

- Older adults with physical, mental health issues (including older adults with Alzheimer's disease or other related dementia, or multiple chronic illnesses)
- Low income older adults
- Older adults who are caregivers
- Aboriginal older adults
- Older adults who are newcomers to Canada or Immigrants (language proficiency issues, separation from family, financial dependence on children, low levels of interethnic contacts, discrimination); and,
- Lesbian, gay, bisexual or transgendered older adults

Older immigrants arriving in Canada under the family class category were highlighted by the Special Senate Committee on Aging as a particularly vulnerable group[40] mainly because they are subjected to a ten-year sponsorship period. As a result, sponsored parents or grandparents are not entitled to any form of social assistance even if they become citizens during this time. This means that these older adults will remain ineligible for the Old Age Security (OAS) and Guaranteed Income Supplement (GIS) benefits that other income-taxpaying older Canadians would receive.[41] In addition, many vulnerable older immigrants would not have had any employment history in Canada, thus making them ineligible for the Canada Pension Plan (CPP) unless they come from a country with a reciprocal pension agreement. This also leads to sponsored older adults having limited or no access to more economic forms of home and community care, or even long-term care, until after being resident for ten years. With many of these older adults having no independent sources of income, as a result they live in a vulnerable state due to their limited options. In being largely dependent on their families, this sometimes places them at increased risk of abuse, exploitation or neglect.

In 1997, the Government of Canada made the decision to reduce the period of sponsorship for spouses and partners from ten to three years in recognition of the potential for abuse in sponsorship arrangements[42] and in line with the time it takes to become a Canadian citizen. Therefore, many argue that a similar reduction of the immigration sponsorship period for parents and grandparents could significantly improve the settlement of sponsored older adults in Canada and alleviate the distress they may experience in the process of integration.

4. Some Forms of Isolation and Elder Abuse Seem to be Regionally Contingent

Available data on family violence demonstrates that despite national awareness efforts previously mentioned, rates of elder abuse can vary significantly by province and territory but with a tendency to occur mostly in rural settings.[43] Police-reported family violence against an older adult, for example, is significantly higher in Canada's territories compared with all other jurisdictions while New Brunswick, Alberta and Saskatchewan were the three provinces with the highest reported rates of family violence (See Table 2).[44] Taken together, these findings help point to complex social, geographic and economic factors underlying higher prevalence of this form of elder abuse in certain regions.

Table 2. Senior Victims of Police-reported Family Violence, by Sex of Victim, Province and Territory[45]

Senior victims of police-reported family violence, by sex of victim, province and territory, 2013

Province and territory	Female victims		Male victims		Total	
	number	rate[1]	number	rate[1]	number	rate[1]
Newfoundland and Labrador	29	63.0	32	78.4	61	70.2
Prince Edward Island	5	39.8	5	46.7	10	43.0
Nova Scotia	68	79.1	40	55.0	108	68.0
New Brunswick	52	76.3	45	76.8	97	76.5
Quebec	476	67.1	260	44.4	736	56.9
Ontario	530	49.7	284	32.1	814	41.7
Manitoba	54	59.2	56	73.4	110	65.7
Saskatchewan	54	66.8	55	80.3	109	73.0
Alberta	182	79.1	143	71.7	325	75.7
British Columbia	255	67.8	216	63.6	471	65.8
Yukon	3	181.8	7	369.4	10	282.1
Northwest Territories	15	1,193.3	10	757.6	25	970.1
Nunavut	15	2,564.1	11	1,708.1	26	2,115.5
Canada	**1,738**	**62.7**	**1,164**	**49.7**	**2,902**	**56.8**

1. Rates are calculated on the basis of 100,000 seniors (65 to 89 years). Populations based upon July 1st estimates from Statistics Canada, Demography Division.

Note: Senior victims refer to those aged 65 to 89 years. Family violence refers to violence committed by spouses (legally married, separated, divorced and common-law partners), parents (biological, adopted, step, foster), children (biological, adopted, step, foster), siblings (biological, adopted, step, half, foster), and extended family. Excludes incidents where the victim's sex and/or age was unknown. Victims aged 90 years and older are excluded from analyses due to instances of miscoding of unknown age within this age category.

Source: Statistics Canada, Canadian Centre for Justice Statistics, Incident-based Uniform Crime Reporting Survey.

Evidence Based Policy Options to Consider

1. Improving Awareness around Social Isolation and Elder Abuse

The federal government has thus far supported general awareness campaigns around issues of elder abuse. While a general awareness exists around the issue of elder abuse amongst Canadians, specific forms of elder abuse, such as financial abuse, are on the rise and require a better public understanding of how to identify and effectively deal with these issues.

The federal government has also funded work that has further identified older populations that are most at risk of social isolation and elder abuse as well.[46] In particular, rural and aboriginal populations have been identified as being at particular risk of experiencing social isolation as well as violent crimes. Understanding and addressing the complex cultural and societal issues related to social isolation and elder abuse, will require a multi-faceted approach. The federal government is in a position to lead the development and dissemination of more general and specifically targeted approaches to raising awareness and preventing social isolation and elder abuse in partnership with provinces and territories.

2. Addressing the Higher Rates of Elder Abuse in Rural, Aboriginal and Immigrant Populations

Identifying the factors that drive some forms of elder abuse is highly important for designing targeted elder abuse interventions. The evidence is clear that social, cultural, geographical and economic factors likely play a significant role in regional patterns and presentations of elder abuse that exist. Furthermore, rural dwelling older adults are also increasingly prone to social isolation, neglect and other forms of abuse by virtue of living rurally – that is to say, that in many rural communities where access to transportation and/or services are sparse or nonexistent. As a result, when older adults in these settings are forced to outlive their decision to stop driving, their ability to stay connected and access supports and services is immediately challenged. The federal government could therefore provide leadership to prioritize work that helps to understand and address issues of social isolation, abuse and violent crimes in these communities.

In 1997, the Government of Canada made the decision to reduce the period of sponsorship for spouses and partners from ten to three years in recognition of the potential for abuse in sponsorship arrangements[47] and in line with the time it takes to become a Canadian citizen. Older immigrants were highlighted by the Special Senate Committee on Aging as a particularly vulnerable group and the only remaining group to be required to endure a 10 year sponsorship period.[48] In line with the recommendation of the Special Senate Committee on Aging, the Government of Canada should reduce the immigration sponsorship period for older relatives and the residency requirement for entitlement to a monthly pension under the Old Age Security Act be reduced from ten to three years as well in order to significantly improve the settlement of sponsored older adults in Canada and alleviate the risk of abuse they may experience in the process of integration.

Evidence-Informed Policy Brief # 2

Ensuring Older Canadians do not Live in Poverty by Improving their Income Security

Ensuring Older Canadians do not Live in Poverty by Improving Their Income Security

Setting the Context:

Supporting older Canadians to remain independent and engaged citizens will require a concerted effort to strengthen existing and future income and savings opportunities. Over the last 40 years, we have made great strides in reducing poverty rates among older Canadians; falling from one of the highest rates of poverty among older adults in Organization for Economic Co-operation and Development (OECD) countries, to one of the lowest.[49] But we still have some way to go.

Currently, there seems to be clear evidence that older Canadians remain some of the most financially vulnerable members of our communities. Indeed, Canada's Federal Poverty Reduction Plan (2010) lists older adults as one of the nine demographic groups most vulnerable to low-income rates.[50] A recent report by Statistics Canada on Canadian Income further noted that of those included 606,000 older Canadians live "in low income" according to the after-tax low income measure (LIM-AT) (see Tables 3 and 4 for LIM-AT income thresholds and median LIM-AT by province).[51]

Table 3. Annual LIM-AT Cut-Offs by Household Size in Canada[52]

Household Size	After-tax low income threshold ($)
1 person	19,460
2 persons	27,521
3 persons	33,706
4 persons	38,920

Table 4. Annual Median LIM-AT for Families and Unattached Individuals by Province[53]

Province	Median LIM-AT of families of two or more ($)	Median LIM-AT of unattached individuals ($)
Newfoundland and Labrador	64,500	22,100
Prince Edward Island	61,100	23,300
Nova Scotia	62,900	26,300
New Brunswick	59,300	23,200
Quebec	64,000	26,200
Ontario	73,700	26,600
Manitoba	68,100	27,400
Saskatchewan	77,300	32,000
Alberta	92,300	36,500
British Columbia	72,200	25,200
CANADA	**71,700**	**27,300**

In order to reduce the risk of poverty amongst older Canadians, specific federally administered and publically-funded income supports known as Old Age Security (OAS) and the Guaranteed Income Supplement (GIS) for individuals 65 and better have been introduced in Canada over the past few decades. These two programs complement the federally administered and contribution-based Canada Pension Plan (CPP) or Quebec Pension Plan (QPP) that all working Canadians are expected to contribute towards throughout their lifetime. (See Table 3 for average OAS, GIS, and CPP/QPP payouts in Canada).

Table 5. Annual OAS, GIS, and CPP/QPP Payouts in Canada

Income Support Vehicle	($)
OAS (Maximum Monthly Payment) *[54]	569.95
GIS (Maximum Monthly Payment)**	Single Individual: 772.83
	Attached Individual: 512.44
CPP/QPP (Average Monthly Payment)[55]	640.23
QPP (Maximum Monthly Payment)[56]	1065.00
Annual Total Single Individual	**23,795.76**
Annual Total Attached Individuals	**20,671.04**
Annual Maximum Quebec Single Individual (QPP)	**28,893.00**
Annual Maximum Attached Individual (QPP)	**25,768.68**

* - Regardless of marital status and based on an individual annual income of $118,055

** - Amounts based on also receiving full OAS

While OAS and GIS deliver an indexed maximum benefit of about $14,000 annually depending on marital status at the age of 65, and the CPP/QPP currently pay an indexed maximum benefit at age 65 of about $11,000, this does not mean Canadians can each count on getting a $25,000 indexed pension from government sources.[57] This is due to the fact that the income-tested GIS benefit is quickly reduced by other income (including C/QPP) while the OAS benefit gradually reduces when retirement income exceeds a threshold of about $65,000. Furthermore, the average eligible benefit paid by C/QPP is about half the maximum. As a result, a typical retiree born in Canada with no other sources of income won't receive $1,200 – $1,300 per month from government sources. For recent immigrants, this amount will be significantly lower for two reasons: 1) residency requirements to qualify for full OAS benefits; and 2) shorter or non-existent C/QPP contribution periods will also affect how much they will be eligible to receive. According to OECD data, federal public supports, such as CPP/QPP, OAS and GIS, have come to account for 39% of gross income for older Canadians – compared to the OECD average of 59%; while their own capital resources and private pensions account for 42% of gross income – compared to the OECD average of 18%.[58] Taken together, this data outlines that older Canadians are having to increasingly rely much more on their own capital resources and private pension schemes than ever before in comparison to most other OECD countries.

While there has always been a need for Canadians to accumulate private retirement savings, the last few decades of economic turmoil has meant a significant decline in the number of Canadians participating in private and workplace pension plans. Currently, 80% of Canada's 3.2 million federal and provincial public sector workers participate in defined-benefit pension plans that typically provide targeted income replacement of 70% of final earnings integrated with Canada Pension Plan (CPP)/Quebec Pension Plan (QPP) benefits after a 35-year career.[59] For those within Canada's private sector, however, less than 30% of employed workers have a pension plan.[60] While increasingly, private-sector pension plans are moving towards defined-contribution plans, even private-sector defined-benefit plans typically offer less generous benefits than in the public sector, and typically have longer qualification periods for early-retirement benefits. Furthermore, if provided at all, indexing typically is ad hoc and occurs at rates below inflation.[61]

The reality is that **11 million Canadians now do not have access to workplace pension plans** and thus have no choice but to rely on available government administered income supports and their private savings.[62] While the use of private savings vehicles like Registered Retirement Savings Plans (RRSPs) and Tax Free Savings Accounts (TFSAs) have been promoted, many Canadians are still not able to take full advantage of them. Understanding the above in an economic climate where an estimated **2.8 million Canadians are currently unemployed or underemployed**, compounded by the fact that most new job creation is less secure (i.e. part-time, temporary, or self-employment), means we placing even more of our future older Canadians at risk of living below our established low-income cutoffs.[63]

What Are the Issues?

1. Certain Older Canadians Remain Particularly Financially Vulnerable

Evidence overwhelmingly demonstrates that single, unattached older adults as well as older women remain the most financially vulnerable members of our society. We know that 6.2% of attached versus 28.5% of single older adults in Canada are considered low-income according to the LIM-AT.[64] Additionally, older Canadian women, "are twice as likely to live in poverty as men"; with 30% of older Canadian women living below the poverty line.[65]

This striking difference can be explained largely due to a greater likelihood of gaps in their workforce participation while at the same time, experiencing longer life expectancies. Life expectancy difference also helps to explain Canadian also represent a significant portion (70%)[66] of the single older adult category mentioned above. Due to prior workforce participation gaps, older Canadian women are therefore far more reliant on publically- funded, federal income supports such as GIS and OAS; versus contribution dependent pension plans like Q/CPP and private pension schemes. In fact, 30% of an older Canadian woman's total income is supported by OAS and GIS, compared to 18% of their male counterparts'.[67] Though supports such as GIS do take into account marital status in an effort to recognize gender inequity in retirement income, the fact that 30% of older Canadian women still live below the poverty line demonstrates that marital status considerations do not adequately offset the gender gap. Inequity of this scale, therefore, remains a cause for great concern and should be addressed in future income support funding reforms.

2. Current Retirement Savings Vehicles are not Sufficient to Support Most Older Canadians

Mounting evidence suggests that current retirement savings vehicles and public pension plan programs are also falling short in supporting many older Canadians as they age. As a way to supplement federally administered income support programs such as CPP, OAS and GIS, personal savings mechanisms have been introduced over the past few decades such as RRSPs and TFSAs. The challenge with these personal private savings vehicles is that only individuals with higher than average annual incomes can reasonably contribute to realize any meaningful income support later in life. Beyond the inherent inequity of relying on the aforementioned private savings vehicles, pension plans are often upheld as being far superior towards an individual's return on investment. The C.D. Howe Institute, the Canadian Centre for Policy Alternatives and others have articulated that, "as a retirement savings vehicle, pension plans are superior to RRSPs in every practical way"[68] principally as they do not rely on private investment products like mutual funds which have some of the highest management fees for Canadians compared to the rest of the world in general. In addition to public plans such as OAS and GIS being accessible to all Canadians, enhanced public pension plans are being promoted as more efficient retirement savings vehicles for Canadians given their ability to reduce administrative costs, the fact they are protected from creditors, require no self-management of funds, and provide greater tax-deferral room for older adults.[69]

However, while being considered a better alternative to personal private savings vehicles, our public pension plan arrangements are not ideal in their current state. That OAS benefits are considered taxable income – meaning the federal government recoups a portion of what it pays out when a single individual may only take home a *maximum* combined OAS and GIS monthly payout of $1,342.78 – remains a cause for concern. Additionally, effective April 2023, older Canadians will have to wait an additional two years to access their GIS and OAS benefits as legislation was passed that will raise the age of eligibility from 65 to 67.[70] While some proponents argue that this will not be a significant issue as many Canadians are expected to continue working beyond the age of 65, but for others who are more likely to perform manual labour and want or need to retire earlier, it is expected to put more older individuals before the age of 67 at risk of living in poverty.

Evidence Based Policy Options to Consider

1. Enhance Existing Public Pension Vehicles to Ensure No Older Canadian Lives in Poverty

Given the personal and societal risks that exist with having more older Canadians unprepared to meet their future financial obligations, the federal, provincial and territorial governments should consider how best to enhance public pension vehicles; particularly as they relate to vulnerable groups such as older adults who are single and women. While a number of arguments have arisen for enhancing contributions and payouts that could occur through the well-respected and managed CPP/QPP program, the Canadian Labour Congress notes as part of its Retirement Security for Everyone campaign, that through simply increasing the maximal GIS payout by 15%, we would immediately lift all older adults out of poverty.[71] The Federal government should therefore take a leadership role in working with the provinces and territories to officially review its possible options for a cost-effective and equitable way of financially supporting older Canadians. These consideration must also recognize that our current experiments of enhancing private savings vehicles have thus far only proven beneficial for Canadians who already have higher than average income.

Evidence-Informed Policy Brief # 3

Ensuring Older Canadians have Access to Affordable Housing and Transportation Options

National Seniors Strategy Evidence Informed Policy Brief #3

Ensuring Older Canadians have Access to Affordable Housing and Transportation Options

Setting the Context:

If we want to support older Canadians to live independently in their communities for as long as possible, we need to ensure that they can continue to access appropriate, secure and affordable housing and transportation options as they age. Given that housing and transportation costs continue to rise faster than inflation, and that older Canadians tend to outlive their decision to stop driving by a decade, enabling their access to these fundamental needs will be central to enabling their continued independence.

According to the Government of Canada and the Canadian Mortgage and Housing Corporation (CMHC), affordable housing is officially considered affordable, "if shelter costs account for less than 30 per cent of an individual's before-tax household income".[72] A 2010 report, however, outlines that approximately 50 per cent of older Atlantic Canadians spend 30 per cent of their income on housing; while 20 per cent spend over 40 per cent of their income on housing, making them some of the most financially vulnerable individuals in Canada.[73] Perhaps more problematic is the finding that the majority of older Canadians are considered to have a "core housing need", meaning that **"30 per cent of their income was not sufficient to pay the median rent for housing"** in their region.[74] Understanding the affordable housing landscape is not always clear in Canada, as several types of housing exist along a continuum and include public, private and not-for-profit subsidy (see Figure 1). We do know, however, that a lack of access to affordable housing increases the likelihood of physical and mental health problems for older Canadians and yet, the federal government appears to be progressively eliminating the assistance it providers for low-income households and the provision of affordable housing.[75,76] Additionally, simply having a place to live may not be sufficient to support ageing in place, unless the older person is able to ensure it can also meet their needs as they age (see Age-Friendly Environments brief for more information). As a result, for a growing number of older Canadians, having the additional resources to make a home more accessible, to address a growing presence of functional limitations that can occur as we age will also be important.

Figure 1: Canada's Housing Continuum

Emergency Shelters	Transitional Housing	Supportive Housing	Subsidized Housing	Market Rental Housing	Market Home-ownership Housing

*Adapted from Canadian Mortgage and Housing Corporation (2015)[77]

Alongside housing needs exists the need for access to affordable transportation services as we age. Our current demographic shifts are already presenting imminent and serious implications for transportation infrastructure planning considerations across the country and especially in rural and remote communities. For many older Canadians, driving a motorized vehicle has become the primary method they have become reliant upon for travelling around for most of their lives. Therefore, for many older Canadians, being able to drive is an important way of staying active, independent, and socially connected with others. Furthermore, even as older Canadians elect to stop driving, travelling as a passenger in a private vehicle becomes their main form of transportation.[78] In a detailed report around the transportation habits of older Canadians, Martin Turcotte outlines five key issues that will need to be addressed to avoid the impending transportation crisis, namely[79]:

1. The vast majority of older Canadians hold drivers' licences up to and beyond 85 years of age – **3.25 million Canadians over 65, or three quarters of all older Canadians, have a driver's licence** – and this number will dramatically increase over the next decades. While older adults are in general safe drivers and are involved in fewer collisions than teenage drivers, as we age, we are more likely to experience cognitive or physical changes that can significantly affect how well we drive;
2. On average, older Canadians reside in communities where cars remain the primary mode of transportation;
3. The vast majority of older Canadians do not take public transit and express a preference for driving – **84 per cent of men aged 64 to 75 use their own vehicle as their primary form of transportation;**
4. Accessible transit and taxis are considered a "last resort" for getting around up to age 85, and even then, only 9% of older Canadian women indicate it as their primary mode of transportation; and
5. Over a quarter of individuals diagnosed with Alzheimer's disease or some form of dementia hold a drivers licence, and nearly three quarters of them reported driving a vehicle in the month prior.

When older adults decide to stop driving, it is imperative that we ensure that various alternative and accessible transportation options are in place. Therefore, programs that help older adults maintain their independence and mobility, and allow them to travel wherever they want to go in the community safely, and in an accessible and affordable way, is extremely important. Without these, the burden of having to provide transportation supports is likely to fall on family, friends or other unpaid caregivers. A 2008 Statistics Canada report noted that transportation burden affected 80% of caregivers surveyed[80] - a burden that is only likely to increase. Finally, there exists a clear link between social participation rates and one's access to transportation such that lack of transportation negatively impacts social participation rates, which in turn negatively impacts one's overall health outcomes (see Social Isolation brief for more information).[81] Therefore, understanding the importance of having access to transportation in the larger context of ensuring the health and wellbeing older Canadians is essential towards the development of successful 'ageing-in-place' and 'age-friendly communities' policies.

What Are the Issues?

1. Federal Supports for Affordable Housing are Dwindling while Existing Funding Models are Complicated

The federal government has historically played a significant supporting role in funding the development of affordable and social housing. Current federal commitments for affordable and social housing, however, are set to expire. In 2006, these commitments amounted to over $1.08 billion; however, at the current rate of decline, federal social housing transfers to the provinces and territories will be 0$ by 2032.[82]

It is also estimated that the current cuts in federal affordable housing transfers will result in 200,000 Canadian households, including older households, losing their rental assistance by 2020.[83] While housing subsidies and funding come from all levels of government, they are also governed by multiple interwoven agreements among numerous government and non-governmental organizations.[84] Understanding how current declining investments in affordable housing and the ability of older Canadians to afford their living expenses will evolve is not clear, but what is clear is that not addressing this issue will drive more older Canadians to become under housed, homeless or require premature placement into a publicly subsidized nursing home. The latter situations are extremely undesirable given such services and supports come at a greater expense to Canadian taxpayers. What is required is better information on current and projected needs for affordable housing among older Canadians so that evidence-informed responses can be appropriately developed and supported in the most cost-effective ways for Canadian taxpayers.

2. Certain Groups of Older Canadians are Particularly Challenged in Accessing Affordable Housing and Transportation

According to Statistics Canada, older Canadians who live alone, are 85 years old or better, are female, have lower incomes, rent rather than own their dwelling, reside in large cities, or have mental health and addictions problems are more likely to experience housing affordability issues than other Canadians.[85]

When it comes to transportation, older Canadian women compared to men are the most likely to have their activities of daily life limited by transportation challenges both because they are less likely to hold drivers licenses and because they are less likely to take accessible public transit as they age.[86] Indeed, amongst those aged 85 and better and living in private households, only 26% of older women, compared to 67% of older men in this cohort hold driver's licenses.[87]

Furthermore, this trend also exists amongst younger women aged 65-75 and thus will continue to be an issue for the foreseeable future. Current municipal strategies that aim to provide transportation subsidies or services for the elderly are largely focused in metropolitan areas where economies of scale support the provision of subsidies and services, putting those in rural areas at further risk of social isolation. However, the evidence also shows that even in areas where public transportation services are available, less than 10% of older Canadians use public transit.[88] While a growing number of community agencies are developing subsidized community transportation that offer older adults rides in private cars and vans, these may be only available in communities large enough to host them, and for specific transportation needs (e.g. transportation to a medical appointment). Without sufficient and affordable transportation options, the provision of transportation support continues to fall disproportionately on family members and friends to get around – an unsustainable solution to help the growing ranks of older Canadians to remain independent in their communities.

Evidence Based Policy Options to Consider

1. We Need Maintain and Prioritize a Federal Commitment to the Development of Housing and Transportation Infrastructure that Can Support the Independence of Older Canadians

Maintaining and Growing the Federal Government's longstanding investments in the development of affordable housing has allowed many older Canadians to maintain their independence. Given that housing affordability is becoming a growing issue across the country, continuing and prioritizing investments that especially support more vulnerable groups of older Canadians access needed housing supports will enable more individuals to age in the place of their choice.

Identifying and promoting other enablers to ageing in place, such as home renovation subsidies, and property tax deferral programs especially for low-income older households will further enable ageing in place. Meeting the evolving transportation needs of older Canadians will not be solved simply with the provision of more public transportation services, especially when less than 10% of older Canadians choose to use it. Therefore, supporting the provision of research and funding that can enable the development of popular, accessible, and dignified transportation strategies that can support both urban and rural older adults will be integral to supporting older adults to maintain their independence in their communities.

Evidence-Informed Policy Brief # 4

Enabling the Creation of Age-Friendly Physical Environments and Spaces

National Seniors Strategy Evidence Informed Policy Brief # 4

Enabling the Creation of Age-Friendly Physical Environments and Spaces

Setting the Context:

With a growing number of older Canadians expressing their desire to remain in their homes and communities for as long as possible, also referred to as 'ageing-in-place,' the federal government along with its provincial, territorial and municipal counterparts have been increasingly promoting and supporting the creation of World Health Organization (WHO) designated Age-Friendly Cities and Communities across Canada.

In 2006, the WHO launched its age-friendly communities initiative to promote a more thoughtful approach to the development of communities that could promote the health and well-being of people of all ages, and especially our ageing population. An age-friendly community, as they define it, is one that recognizes the great diversity amongst older persons, promotes their inclusion and contributions in all areas of community life, respects their decisions and lifestyle choices, and anticipates and responds flexibly to ageing-related needs and preferences. Essentially, they are places that encourage active ageing by optimizing opportunities for health, participation, and security in order to enhance quality of life as people age.[89]

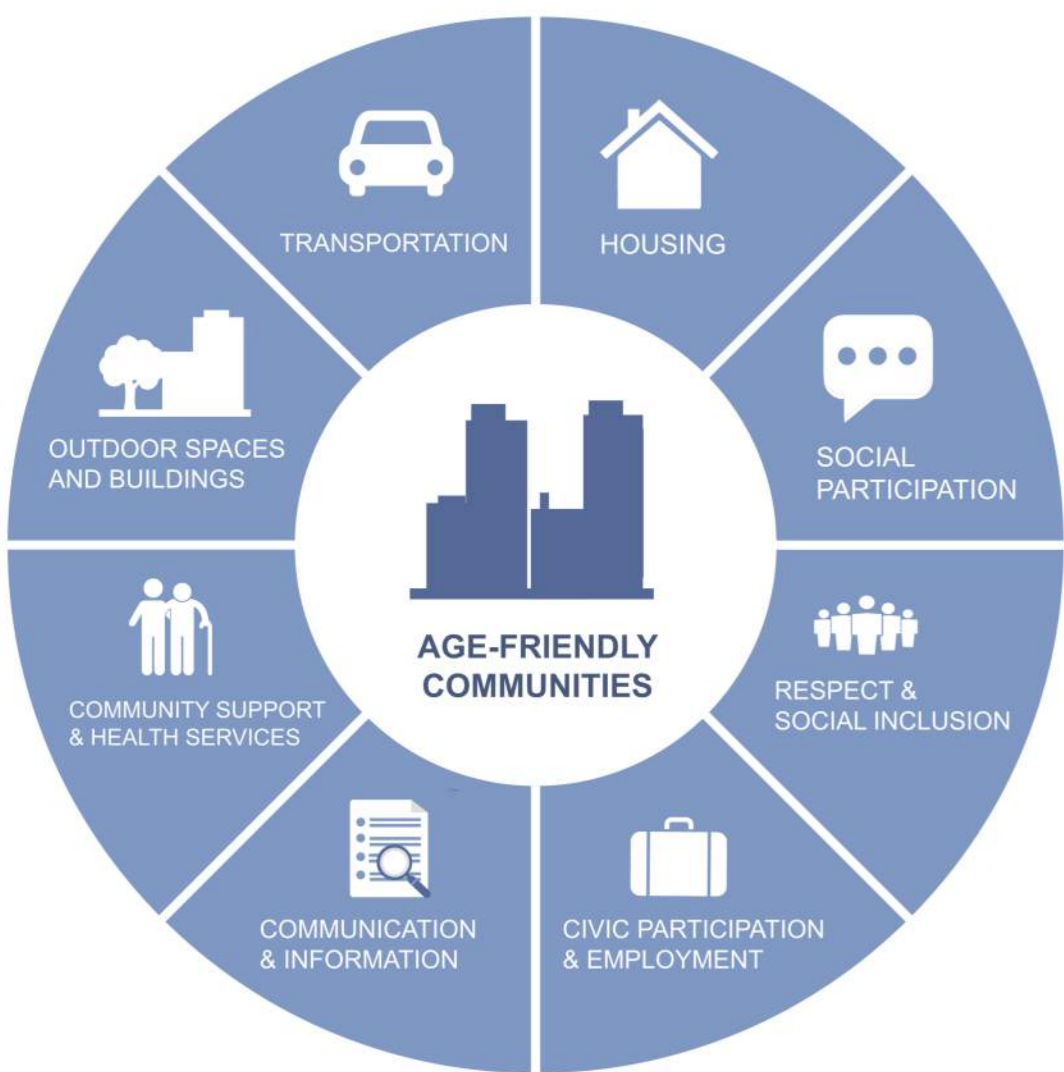
Making our communities more age-friendly should be understood as a practical response to promote the contributions and well-being of older residents who keep our communities thriving. Adapted environments and services that are accessible to, and inclusive of, older people with varying needs will further encourage them to engage more frequently in community activities. Furthermore, creating a culture that respects and includes older people as well will foster strong connections and personal empowerment.

Across Canada a number of communities have taken part in age friendly community development activities at various levels. Through these activities, participating communities have learned to assess their level of "age-friendliness," how to integrate an ageing perspective into urban planning, and how to create age friendly spaces and environments. To date, 17 Canadian communities across British Columbia, Alberta, Manitoba, Ontario and Prince Edward Island have successfully met and been awarded the WHO's Age-Friendly City (AFC) official designation (see Figure 2 for the complete list). The WHO has identified eight domains of community life that influence the health and wellbeing of older persons, and serve as the basis around which AFC's are expected to focus their efforts.

Figure 2. WHO Framework for Age-Friendly Cities & Communities

RESPECT AND SOCIAL INCLUSION	Are public services, media and faith communities respectful of the diversity of needs among older persons and willing to accommodate?
SOCIAL PARTICIPATION	Do elders have opportunities that allow for the development and maintenance of social networks within their neighbourhood?
CIVIC PARTICIPATION & EMPLOYMENT	Do older persons have opportunities to participate in community decision making and employment and volunteerism that caters to their abilities and interests?
OUTDOOR SPACES & BUILDINGS	Can older persons get around easily and safely in the community?
HOUSING	Do older persons have homes that are safe, affordable, and conveniently located while promoting independence as their functional needs change?
TRANSPORTATION	Can older persons travel wherever they want to go in the community, safely and in an accessible and affordable way?
COMMUNICATION AND INFORMATION	Are older persons and their families aware of the diverse range of programs and services available within their community and communicated to in accessible ways?
COMMUNITY AND HEALTH SUPPORT	Do older persons have access to social and health services they need to stay healthy and independent?

While this evidence brief focuses on the AFC domain related to development of age-friendly buildings and spaces, the other briefs focus on the other AFC domains: respect and social inclusion, social participation, communication and information, civic participation and employment, transportation, housing, and community support and health services.



The WHO's approach to the development of age-friendly physical environments acknowledges the importance of including meeting the needs individuals across all ages to encourage integration and interaction across generations. For example, the benefits of developing accessible and age-friendly playgrounds can create a valuable space for older Canadians to interact with their grandchildren and younger community members, a concept that the City of Edmonton has widely embraced in their plan for the creation of an 'Age-Friendly Edmonton'.[90]

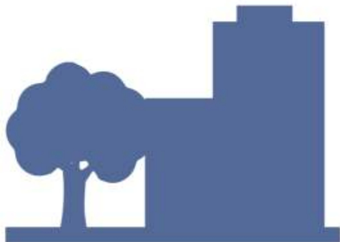
Furthermore, evidence demonstrated that there tends to exist greater community support if the development of age-friendly buildings and spaces are not targeted at older people alone, but are recognized as being of value to other populations as well.[91] Finally, the WHO's AFC initiative reminds us that our personal living spaces must be considered a part of a larger age-friendly environment we inhabit and must be built with this notion in mind if we are to create truly accessible and welcoming environments.

Thus far, the Public Health Agency of Canada (PHAC) has played a significant role in advancing the WHO's Age-Friendly Communities Initiative. PHAC provided funding towards the development of the original WHO Age-Friendly Cities Guide[92] and the Pan-Canadian Age-Friendly Communities Milestone Guide[93] to help communities implement Age-Friendly requirements in their local settings. The CIHR's Institute of Aging and the Canadian Association of Gerontology have also provided significant support of research and knowledge synthesis/translation activities to inform the evaluation of age-friendly communities. Finally the CMHC has also sponsored initiatives to provide guidance around the development of physical environments for individuals with specific age-related limitations such as dementia as well as their FlexHouse Checklist[94] to support the development of accessible, affordable, and adaptable housing plans.

What Are the Issues?

1. Not Enough Emphasis is Being Placed on the Accessibility of Buildings and Spaces Canadians Use

Accessibility is a significant consideration towards the development of AFC cities and communities. While accessibility can be considered in a variety of ways, from a physical design standpoint, the spaces and buildings we use for living, work and recreational purposes must be, at a minimum, accessible to older Canadians to ensure they can actively participate in their environments.



Accessibility encapsulates not only the mere ability to access an environment, but that such an environment is safe to access for individuals with any form of physical limitation. While there are specific considerations that take into account the particular needs of older people, more 'universal' design standards are now being promoted that can take into account the potential and often common needs of all members of the communities we live in.

While individual provinces have made legislative commitments to ensuring greater accessibility (for example, see the 2005 Accessibility for Ontarians with Disabilities Act[95]; or the more recent 2013 Accessibility for Manitobans Act[96], not all Canadian jurisdictions have made this level of commitment towards improving accessibility. Furthermore, the legislation that currently exists extends mostly to public environments and/or businesses and less so to the dwellings we live in. While Canada's National Building Code (NBC)[97] does outline some accessibility requirements for private dwellings, provinces vary in their interpretation and implementation of these requirements.[98]

For example, design standards and requirements for the creation of barrier-free or accessible residential units seem to be jurisdictionally contingent. In Alberta, for example, a minimum percentage of publically-funded housing must have accessible units while in Ontario and Nova Scotia, this applies to privately funded dwellings as well.[99] Furthermore, the minimum percentage requirements to support the development of accessible units varies by province. For example, 5% of all multi-family buildings in Nova Scotia must be accessible versus 10-20% in Alberta.[100] What is also clear is that there has been a lack of robust federal legislative or other commitment towards the development of a national standard around building accessibility in Canada.

2. Rural and Remote Settings Struggle the Most with Creating Accessible Environments

While the WHO's Age-Friendly Cities initiative focuses primarily on adapting urban settings, the standards it promotes are largely applicable in any community setting. Despite this, the need for the creation of more age-friendly physical environments and spaces is particularly acute in rural areas.

The Public Health Agency of Canada (PHAC) highlighted that older adults and caregivers from rural and remote settings consider walkability to be one of the most important features of their communities – and also happens to be a feature that is often lacking in rural communities.[101] A common barrier cited as causing a lack of walkability in these settings is a lack of sidewalks, or continuous sidewalks, resulting in the need to walk or using mobility devices on streets and highways.[102] This lack of proper sidewalks also exacerbates the reliance on driving private vehicles to get around, worsening transportation issues for rural older Canadians. With more than 6.3 million Canadians[103] currently living in rural areas who tend to be ageing faster than urban areas in the country, ensuring older rurally dwelling Canadians are able to age-in-place in more rural and remote communities will need to be a focus of any efforts to improve the accessibility of Canadian communities.

Evidence Based Policy Options to Consider

1. Develop National Standards that Promote Accessibility for All Canadians

Given the growing diversity of our population and the fact that as we age, more Canadians will be living in their communities with physical and cognitive limitations, there exists a clear opportunity for federal leadership to help align existing national standards and frameworks. The efforts of our current provinces and territories to enable a common minimum standard in our National Building Codes has thus far been variable across the country. We should also recognize that setting standards of this sort, such as minimum percentages of accessible units are only *minimum requirements*. To foster truly age-friendly spaces, the federal government should exercise leadership in encouraging provinces and municipalities to aim beyond minimum standards.

2. Support the Development of More Age-Friendly Communities

Building on the prior work and investments by federal agencies such as PHAC, CIHR, CMHC, there needs to be a renewed federal mandate to first understand the progress that has been made on the implementation of the Age-Friendly Communities agenda across Canada and to understand what needs to be done to support the development of more Age-Friendly Communities. Using its strength as a proven enabler and convener, there exists a clear opportunity for the federal government to renew its prior roles in advancing this important agenda.

Finally, a significant proportion of Canadians continue to live in rural and remote communities. Nearly a decade ago the federal, provincial and territorial ministers responsible for seniors came together to create a guide to promote the development of *Age-Friendly Rural and Remote Communities*.[104] In addition to general universal design principles and initiatives that the federal government can promote, it should not forget that rural and remote communities require more support and guidance to eliminate barriers and promote the adoption of age-friendly activities.

SECTION 2

THE SECOND PILLAR

Healthy and Active Lives

PILLAR 2: HEALTHY AND ACTIVE LIVES

ENSURING OLDER CANADIANS CONTINUE TO LEAD HEALTHY AND ACTIVE LIVES FOR AS LONG AS POSSIBLE

Important advances in public health and health care over the last few decades mean that most Canadians are now living longer and with fewer health problems than ever before. In the future we need to do more to educate and support Canadians to participate in activities that promote wellness, prevention and overall healthy ageing so that more older Canadians can age in good health and stay independent in their communities for as long as possible.

The Federal Government and the Public Health Agency of Canada can work with Canada's provinces, territories and municipalities to enable this pillar and associated activities in a variety of ways.

- **Ensuring Canadians are Supported to Engage in Wellness and Prevention Activities that Enable Healthy Ageing**

  Ensuring Canadians understand the importance of activities that support healthy ageing and the prevention of age-related diseases and are empowered and supported to regularly exercise, develop strategies for falls prevention, and get recommended vaccines. Read more on this opportunity in Evidence Brief #5.

- **Improving Access to Medically Necessary and Appropriate Medications**

  Ensuring that all Canadians have access to medically necessary and appropriate medications for the management of acute and chronic diseases will allow Canadians to live healthier and longer lives in their communities. Read more on this opportunity in Evidence Brief #6.

- **Ensuring Older Canadians and their Caregivers are Enabled to Participate in Informed Health Decision-Making & Advance Care Planning**

  Ensuring Canadians have a better understanding of the importance of advance care planning will support Canadians to become more engaged in decision-making around their health care and empower them to make more informed decisions. Read more on this opportunity in Evidence Brief #7.

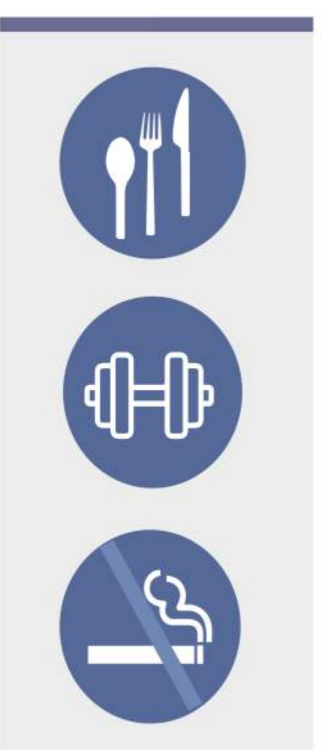
Evidence-Informed Policy Brief # 5

Ensuring Canadians are Supported to Engage in Wellness and Prevention Activities that Enable Healthy Ageing

National Seniors Strategy Evidence Informed Policy Brief # 5

Ensuring Canadians are Supported to Engage in Wellness and Prevention Activities that Enable Healthy Ageing

Setting the Context:



Supporting healthy ageing requires that we emphasize wellness and prevention opportunities for all Canadians especially when we know that they can make a real difference to our later-life health-related outcomes and costs. All Canadians, and not just older Canadians, can benefit from a greater understanding of how the things they do earlier in life can better ensure their overall health and wellness later in life.

Encouraging proper nutrition, regular physical exercise, interventions such as vaccinations, and the avoidance of certain activities like smoking across the lifespan have been well shown to reduce one's chance of developing a variety of chronic diseases and extend an individual's overall life expectancy. In fact, through better managing our vascular risk factors, we are even seeing an overall decline in the prevalence of dementias across the population.[105,106]

The greatest barrier to advancing healthy ageing is that as Canadians, our 'health literacy' skills or ability to access, understand, evaluate and communicate information as a way to promote, maintain and improve health in a variety of settings across the life-course[107] remains extremely low.

In fact, it was recently demonstrated that **only 12% of older adults have adequate health literacy skills to support them in making basic health-related decisions.**[108] Therefore, any broad efforts to support healthy ageing will need to place an equal emphasis on improving the health literacy skills of Canadians to ensure they can both appreciate and understand the things they can do to stay healthy and independent for as long as possible.

With respect to accessing information and resources that promote healthy ageing, while using 'online' methods is seen as an effective way to do so, we must not forget that only 60% of Canadians age 65-74 have ever used the internet and that this number drops significantly to 29% for those over 75.[109]

Therefore, while the older demographic are amongst the fastest growing demographic using the internet, improving our health literacy and overall awareness of important issues will need to be done in a variety of ways that reflect the many ways older adults still access information while being respectful of our growing ethno-cultural diversity as Canadians.

In particular, this brief focuses on two very specific areas where the federal government's primary role in addressing public health issues could be leveraged: 1) by ensuring the majority of older Canadians obtain their federally recommended vaccinations; and 2) by leading an increased emphasis around promoting awareness and activities to support falls prevention amongst older Canadians.

What are the Issues?

1. The Majority of Older Canadians are not Receiving their Recommended Vaccinations

The vast majority of Canadians ensure that our children and young adults are getting the vaccinations recommended for them. What fewer Canadians appreciate is that there are recommended vaccinations specifically for older Canadians like the influenza, pneumonia (pneumococcal) and shingles (varicella/herpes zoster) vaccinations.

Additionally, the tetanus vaccination is one we are recommended to take at regular intervals across the lifespan. As a result, overall vaccination rates among adults in Canada remain far lower (See Table 6) than the Public Health Agency of Canada's (PHAC) previously set 80% target immunization rates for those 65 and older by 2010.[110]

With evidence showing the overall positive benefits of taking the annual influenza vaccination[111] Canadian public health authorities have made the greatest progress in advancing the uptake of the influenza vaccine in particular among older adults, yet the uptake rate of other more efficacious vaccines such as the pneumococcal, shingles and tetanus vaccinations have even lower rates of coverage amongst older Canadians (See Table 6).

Table 6. Estimated Rates of Recommended Vaccination Coverage among Older Canadians as of 2012[112]

Risk Group	Seasonal Influenza	Pneumococcal	Varicella/ Herpes Zoster	Tetanus
65+ years of age [113]	64.9%	38%	3.9%*[114]	-
General Population [115]	37%	-	-	49% [116]
Additional coverage needed to meet 80% target	15.1%	42%	76.1%**	31%

* - Canadian coverage rate not available. Figure reflects US Herpes Zoster vaccine uptake rates among older adults;
** - Estimated based on US data

"4,000-8,000 Canadians are at risk of death annually due to influenza, with the vast majority being amongst individuals 65 years and older."

Low vaccination rates among older Canadians is of concern since many preventable illnesses and their substantial associated costs could easily be avoided with better uptake of these vaccinations. With respect to influenza alone, between **4,000-8,000 Canadians are at risk of death annually due to influenza,**[117] **with the vast majority being amongst individuals 65 years and older.**[118]

Furthermore, costs related to the lost productivity costs due to influenza amount to over **$1.5 billion** annually.[119] We also know that individuals over 65 years old make up one-third of all community acquired pneumonia cases;[120] largely caused by one strain of pneumonia that the pneumococcal vaccine specifically targets. Despite this, only 38% of older Canadians have received the pneumococcal vaccination.

Finally, **90% of Canadians are at risk of developing shingles** because they have had chickenpox earlier in life,[121] yet less than **5% of older Canadians have been vaccinated against shingles.** This probably explains why 130,000 Canadians are still diagnosed with shingles each year, resulting in 252,000 physician consultations, 2,000 hospitalizations a year, and significant treatment-related costs.[122]

The opportunity to further advance the promotion of vaccinations among older adults through focused awareness campaigns and leveraging as many health care providers and points of care to offer this vaccination should be acted upon. Indeed, in a growing number of provinces, pharmacists are now being given training and support to deliver influenza vaccinations each year, while nearly all provinces have ensured that the vaccination can be provided at no cost to recipients. However, not all older Canadians have access to universal coverage for the influenza vaccine. In Quebec, for example, **individuals 65 and over do not have access to publically funded influenza vaccinations.**[123] Where vaccines recommended for older Canadians by the Public Health Agency of Canada (PHAC) are provided at no out of pocket cost, identifying barriers to uptake is still required to address low vaccination rates.

2. Falls Amongst Older Canadian are Common and Costly and Yet Largely Preventable

Falls amongst older Canadians cannot only threaten their independence and overall well-being, but they account for an estimated at **$2.2 billion dollars annually in related-health care spending across Canada** to address the consequences related to them.[124] Furthermore, older Canadians who are hospitalized due a fall are in hospital on average nine days longer than for any other reason.[125] In Canada, between **20-30%**[126] of older adults fall annually and with current demographic imperatives, the systemic burden associated with falls is only likely to increase if current trends persist.

Causes of falls among older adults are usually multifactorial. Some of the leading causes of falls include: the presence of chronic and acute health conditions that can negatively impact a person's strength and balance, independent balance or gait deficits, decreased sensory abilities, inadequate nutrition, social isolation, and challenges with our existing built environment.[127]

While there has been a concerted effort on behalf of PHAC to raise awareness of falls prevention strategies, there is much to be learned by provincial and local falls prevention programs. For example, the Government of Ontario recently began offering two thousand free exercise and falls prevention classes throughout the province for anyone 65 and over.[128] Classes of this nature have been designed to address a multitude of physical factors causing falls and also provide older adults with the opportunity to socialize with others in their community and thereby strengthen their social networks to help combat social isolation. What's more, this initiative is operated with extremely low overhead, as it is funded with a small annual provincial investment and delivered in publically accessible locations by existing community support services agencies.

Other examples of provincial initiatives to reduce falls include occupational therapy home assessment strategies such as the *Ontario Occupational Therapy (OT) In-Home Senior Safety Assessment Program*[129] and home renovation tax credit programs like the *Healthy Homes Renovation Tax Credit Program* in Ontario that the federal government recently pledged to make available across the country in its 2015 budget.[130] While the *Healthy Homes Renovation Tax Credit* is a step in the right direction, to receive the maximum 15% benefit of $1,500 towards a renovation,$10,000 must have been spent towards the renovation.[131] A more accessible home renovations support program is the recent *Seniors Safe @ Home Program* in Prince Edward Island which allows up to $5,000 in forgivable grants to lower income older adults to support home renovations.[132] OT home-safety assessment and related home renovation programs are supported by the evidence and are currently recommended by PHAC for the prevention of falls among community dwelling older adults.[133,134,135] Therefore, making these services available and accessible for all older Canadians should be considered an essential component of any national falls prevention strategies.

Nevertheless, in Ontario and other jurisdictions where falls prevention activities are being provided at no out of pocket cost to participants, identifying other barriers to participating (such as having

suitable complementary transportation services to get people to the classes) is still required to address this significant issue. Falls awareness and prevention activities must also be provided to older adults in a way that is most accessible to them. Additionally, the federal government should make use of existing investments such as PHAC' *Participaction* Program to focus on falls prevention for older adults as well.

Evidence Based Policy Options to Consider

1. Strengthen the Mandate of the Public Health Agency of Canada to Better Address Issues of National Importance for Older Canadians

The federal government is in a unique position to leverage its own existing and underutilized institutions and resources to strengthen the mandate of the PHAC to more adequately address two major issues of national importance for all older Canadians: Improved Vaccination Uptake and Falls Prevention.

It has been well established that the financial savings that could likely be rendered to provincial and territorial health systems through the better uptake of recommended vaccinations could be significant. PHAC could help to work with the provinces and territories to lead significant and consistent awareness campaigns at the national level while also supporting the development of more consistent and coordinated approaches to vaccination and falls prevention activities across the provinces and territories.

With respect to supporting the development of more consistent approaches, PHAC could support the call for the universal provision of influenza, pneumococcal and tetanus vaccinations for all Canadians over 65. When a more fridge stable and less costly form of the shingles vaccination becomes available, this too should be added to the list. While, we have regrettably failed to meet PHAC's previously set 80% target immunization rates for those 65 and older by 2010[136] – federal leadership could help to support a pan-Canadian strategy that could very well meet this goal and lead to a significant reduction in health care costs related to these illnesses.

PHAC recently started to focus more of its attention towards raising awareness of falls, the significant impact falls have on the health and wellbeing of older Canadians and our health system as whole, as well as the importance of their prevention. While the federal government has made substantial investments in programs such as PHAC's Participaction Program it is almost exclusively focused on promoting physical activity amongst younger Canadians. There exists, however, an opportunity to leverage the media reach of Participaction for expanded information related towards the benefits of physical activity throughout our lifespans to promote healthy ageing and falls prevention. Furthermore, supporting the provinces and territories to advance the adoption of successful, low cost and evidence-informed falls prevention programs have the potential to generate significant savings related to current falls-related health care spending, while potentially concurrently addressing other important issues like social isolation. As such, PHAC could play a strengthened role as the key knowledge translation mechanism to spread the adoption of falls prevention best practices across the country.

Evidence-Informed Policy Brief # 6

Improving Access to Medically Necessary and Appropriate Medications

National Seniors Strategy Evidence Informed Policy Brief # 6

Improving Access to Medically Necessary and Appropriate Medications

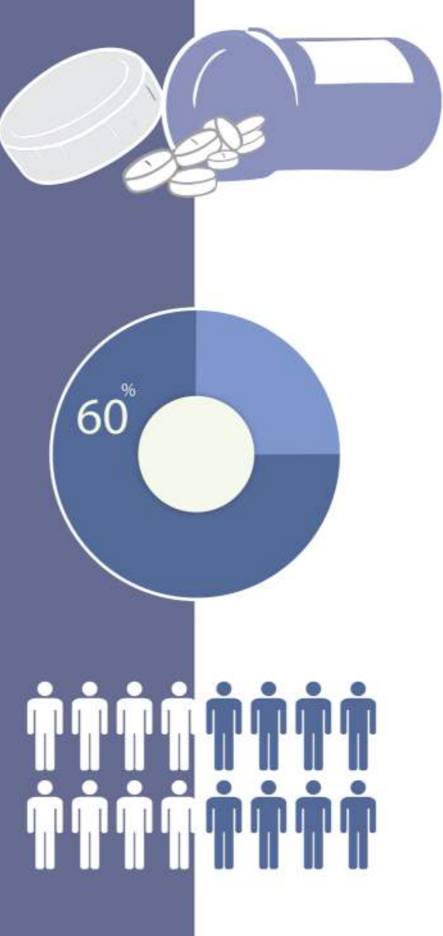
Setting the Context:

As we are more likely to encounter health issues as we age, our ability to access medically necessary and appropriate medications becomes increasingly important.

The majority of Canadians 65 years of age and older are currently living with at least one chronic disease, while a growing number are living with many. In fact, a recent report found that 65% of older Canadians are taking medications belonging to 5 or more medication class; while 39% of adults over the age of 85 are taking medications belonging to 10 or more medication classes.[137]

Older Canadians are indeed fortunate to be provided with access to publically funded prescription medication coverage programs in every province and territory. While, older Canadians account for only 15% of our overall population, they currently account for **60% of the total spending within our provincial and territorial medication programs.**[138]

With the numbers of older Canadians set to double over the next two decades and those over the age of 85 set to quadruple, it is clear that significant funding pressures will also be placed on our publically funded prescription medication coverage programs.



What Are the Issues?

1. Deductibles and Co-Payments Only Serve to Limit Access to Important Medication

Despite having access to publically funded prescription medication coverage programs, minimum income requirements, deductibles, co-payments, and prescription medications covered vary by province. In some regions, low-income older adults are still required to pay a co-payment or deductible for their prescription medications (see Table 7).

This matters as there is widespread consensus from the existing policy research evidence that an individual's access to prescription medications is directly influenced by factors related to their ability to pay, such as income and ability to pay out-of-pocket costs like co-pays and deductibles. **Specifically, the existence of co-payments in prescription medication coverage plans has consistently been found to lead to a decreased utilization of prescribed medications; whereas the reduction or elimination of co-pays and deductibles has consistently resulted in increased adherence.**[139,140,141,142,143]

It also well recognized that the inability to access essential prescription medications often has far more severe health implications for older adults than for other populations, and significantly contributes systemically to increased hospital admissions, re-admission as well as nursing home placements.[144]

The negative impact of co-pays and deductibles on prescription medication access has been recognized and addressed in other universal health care systems such as the National Health Service in the United Kingdom, where individuals over 60 years of age pay nothing out of pocket for medications.[145]

2. How Better Buying Practices Could Better Manage the Costs of Our Publically Funded Prescription Medication Coverage Programs

The Health Council of Canada calculated that prescription drug costs represent the second fastest growing health care cost in Canada at approximately **$25 billion annually.**[146] Currently, the vast majority of the prescription medications our publicly funded programs cover are purchased from pharmaceutical manufacturers at the provincial or territorial level. In negotiating for a smaller population, the current evidence shows that the prices our publically funded programs pay for the medications they cover are significantly higher than other jurisdictions around the world who negotiate at the national level.

While our provinces and territories are starting to purchase certain prescription medications at a national level, research evidence suggests that if we implement a more systematic way to buy all of our medications, we could collectively save our provinces and territories billions of dollars.[147]

"Older Canadians account for 57% of all hospitalizations due to adverse drug events (ADEs)."

3. There is an Additional Cost Related to the Inappropriate Prescribing of Medications to Older Canadians

Ensuring older Canadians who need to take medications are on the appropriate ones is not only important to ensuring their overall health and independence but represents an equally important way to control avoidable health care costs.[148] Indeed, the use of inappropriate prescription medications among older adults is a known correlate of avoidable hospitalization and hospital readmissions due to adverse drug events (ADE).[149]

Furthermore, while evidence-based lists of inappropriate medications for older adults, such as the Beers List, are widely accepted, published and accessible, nearly **40% of older Canadians are currently taking one inappropriate medication with an additional 12% taking multiple inappropriate medications.**[150] Mounting evidence supported by the Canadian Geriatrics Society suggests that discontinuing or deprescribing certain potentially inappropriate medications among older Canadians will not lead to adverse health outcomes and will reduce costs associated with ADEs.[151] **In fact, older Canadians account for 57% of all hospitalizations due to ADEs; representing approximately $35.7 million (over 80% of costs related to hospitalization).**[152]

Importantly, with proper oversight, it is estimated that 40% of ADEs are preventable.[153] To address this, many are now recognizing how training health professionals to ensure the proper prescription and monitoring of (in)appropriate medications for older adults will be vital to promoting their health as well as better addressing the avoidable related costs of ADRs.

Table 7. Current Prescription Medication Coverage by Province for Older Canadians

Province	Coverage
British Columbia[154]	Individuals pay their full prescription costs until they reach a threshold level known as their deductible. Once their deductible level is reached, BC PharmaCare begins assisting them with their eligible prescription medication costs for the rest of the year. **N.B** This program applies for all individuals in BC and not just older adults. To ensure annual drug costs do not exceed one's ability to pay, families are also assigned a **family maximum, based on a % of one's net income.** If an individual reaches their maximum, BC PharmaCare covers 100% of their eligible drug costs for the rest of the year. For example, the maximum annual deductible for an individual making $40,000/year is $1200 for a single individual or $1600 for a family. For individuals born before 1939, their family deductible is waived if their net annual family income is less than $33,000. BC PharmaCare then covers 75% of eligible prescription medication costs beyond the level of the deductible. Despite the universal nature of the BC PharmaCare Program, mounting evidence is showing that it now routinely achieves the lowest adherence rates of older adults towards filling their prescriptions due to the associated out-of-pocket expenses related to required deductibles and co-payments.
Alberta [155,156]	Older Albertans and their dependents are automatically provided with premium-free drug coverage. Under this program, older adults pay only 30% of the cost of prescriptions up to a maximum of $25 per prescription. As of July 2010, older Albertans can apply to participate in an optional drug program which features a per prescription co-payment of 20% to a maximum of $15 and a monthly premium. For single individuals with a taxable income of $48,001 or more the premium is $63.50 and for families with a taxable income of $96,001 or more the premium is $118.00. Single individuals and families with smaller taxable incomes, premiums lessen while the co-payment remains 20% of each prescription to a maximum of $15. The lowest income Albertans do not have to pay the co-payment or premium. It is currently estimated that approximately seven per cent of low-income older Albertans receive free prescription medications - they will not pay a co-payment or a premium, while another 49 per cent will pay a co-payment, but not a premium.
Saskatchewan [157,158]	Under the Saskatchewan Seniors' Drug Plan, eligible adults 65 years and older pay up to $20 per prescription for medications listed on the Saskatchewan Formulary and those approved under Exception Drug Status claims. The cost of a prescription was increased from $15 to $20 in March 2012.

Manitoba[159]	Manitoba's Pharmacare coverage is income based and is calculated using Canada Revenue agency information. The minimum deductible for the Manitoba Pharmacare program is $100, with no maximum deductible. Eligible applicants must reapply every year for pharmacare coverage.
Ontario[160,161]	Ontario's Drug Benefit Program employs a co-payment system. Single older Ontarians with an income of more than $16,018 a year, or individuals who are part of a couple with a combined income of more than $24,175 a year, pay a $100 deductible every year for prescriptions filled per person. After that, older adults pay up to $6.11 towards the dispensing fee for each prescription depending on their income levels. Older Ontarians whose incomes fall below the above thresholds pay up to $2 for each prescription filled. As of 2012, high-income older adults (those making over $100,000/year) are required to contribute $100 plus 3% of their income toward their annual deductible.
Quebec[162]	In Quebec, the Public Prescription Drug Insurance Plan is administered by the Régie de l'assurance maladie du Québec and is intended for persons who are not eligible for a private group insurance plan covering prescription drugs, for persons age 65 or over, and for recipients of last-resort financial assistance and other holders of a claim slip (carnet de réclamation). Children of persons registered for the public plan are also covered by that plan. All persons covered by the public plan must pay an annual premium of between $0 and $611, based on net family income, whether or not they purchase prescription medications under the plan. Older individuals receiving 94% to 100 of the Guaranteed Income Supplement are exempt from paying the annual premium.
New Brunswick[163]	Older beneficiaries receiving the Guaranteed Income Supplement are required to pay a co-payment of $9.05 for each prescription, up to a maximum of $500 in one calendar year. Older adults in New Brunswick are otherwise required to pay a co-payment of $15.00 per prescription with no yearly co-payment maximum.
Nova Scotia[164]	Older adults contribute to Nova Scotia's Seniors' Pharmacare Program through premiums and co-payments. Older adults must pay a premium each year to join the Seniors' Pharmacare Program which is calculated based on one's income and the number of months remaining in the program year. Currently, the maximum annual premium for an older adult is $424. Those with individual or joint incomes below $18,000 or $21,000 may be exempted from paying the premium. Older adults receiving the Guaranteed Income Supplement do not have to pay a premium, but still have to pay a co-payment which is 30% of the total cost of each prescription. Currently, the annual maximum co-payment an older adult would pay is capped at $382.

Newfoundland[165]	In Newfoundland, under the 65 Plus Plan, costs of prescription drugs are paid for by the province while the charge for dispensing fee is paid by the older adult. The maximum dispensing fee is $6. Individuals over 65 who receive Old Age Security and the Guaranteed Income Supplement are eligible for coverage.
Prince Edward Island[166]	In Prince Edward Island, at the age of 65, all older adults are automatically enrolled in the province's Pharmacare program that only requires them to pay the first $8.25 of the cost of their prescription medication in addition to and the pharmacist's professional fee (dispensing fee).
Yukon[167]	Yukon residents at least 65 years of age or aged 60 and married to a Yukon resident who is at least 65 years of age, are eligible for Yukon Pharmacare benefits through the Yukon Health Care Insurance Plan (YHCIP). The Yukon Pharmacare program pays the total costs of the lowest priced generics of all prescription drugs listed in the Yukon Pharmacare Formulary, including the dispensing fee.
Northwest Territories[168]	Residents of the North West Territories (NWT), age 60 or over are provided pharmacare coverage through Alberta Blue Cross which administers benefits for older adults on behalf of the NWT government. This program provides older adults with 100 per cent coverage for eligible prescription drug products as defined in Health Canada's Non-Insured Health Benefit (NIHB) Drug Benefit List, when the drug is prescribed by a recognized health care professional and dispensed by a licensed pharmacist.
Nunavut[169]	All individuals over 65 are eligible to apply for the Nunavut Seniors Full Coverage Plan under the Extended Health Benefits Full Coverage Plan (EHB). The EHB pays the full costs of approved prescription drugs.

Evidence Based Policy Options to Consider

1. Improving Access to Medically Necessary Medications for Older Canadians

Older Canadians should never have to make choices about taking medically necessary prescription medications based on their ability to pay. With the evidence clearly demonstrating a negative relationship between co-payments and deductibles to overall medication adherence, the federal government could and should provide leadership in partnership with its provincial and territorial counterparts to ensure that older Canadians, or at least low-income older Canadians as a start, make no out of pocket payments for their necessary medications.

While our provinces and territories are starting to purchase certain prescription medications at a national level, research evidence suggests that if we implement a more systematic way to buy all of our medications, we could collectively save our provinces and territories billions of dollars.

We believe that the savings that could be achieved through improved national prescription medication collective purchasing programs, and avoidable health care costs related to prescription medication non-adherence, could more than offset the costs related to eliminating current out-of–cost payments within provincial and territorial plans.

2. Ensuring Appropriate Prescribing and Deprescribing of Necessary Medications for Older Canadians

Older Canadians should not be prescribed medications that we know can be potentially harmful to their health, when safer alternatives exist. The federal government could and should provide leadership in partnership with its provincial and territorial counterparts to address this issue in two ways. First, the creation of standardized and evidence-based prescribing and deprescribing policies around common provincial and territorial formulary medications could better influence better overall prescribing and deprescribing practices.

Second, ensuring national curriculum guidelines for both entry-to-practice and currently practicing health care professionals such as doctors, nurses and pharmacists who prescribe and dispense prescription medications should be strengthened to include comprehensive training in medically appropriate and inappropriate prescribing and deprescribing for older adults.

We believe that with the availability of more evidence-based prescribing supports and training, health care professional across Canada will be able to contribute to better patient and system outcomes through avoiding consequences and costs attributable to the prescribing and use of inappropriate prescription medications amongst the growing ranks of older Canadians.

Evidence-Informed Policy Brief # 7

Ensuring Older Canadians and their Caregivers are Enabled to Participate in Informed Health Decision-Making & Advance Care Planning

National Seniors Strategy Evidence Informed Policy Brief # 7

Ensuring Older Canadians and their Caregivers are Enabled to Participate in Informed Health Decision-Making & Advance Care Planning

Setting the Context:

Advances in medical treatments and care practices have meant that more Canadians can expect to live longer in their communities with more complex health conditions. As a result, patients, families, and health care providers will be called on more often to make increasingly challenging, complicated decision as it related to their future care needs.

The scope of these decisions can vary widely, and can include such issues as:

- Whether to take a proposed medication that may not cure a problem but prolong life.
- Whether and when to move into a long-term care home.
- Whether and when to use and/or withdraw a feeding tube.

Often, these questions don't have simple medical answers. Rather, they involve things at the heart of health care: an individual's values and preferences. These are weighty matters.

Yet, often, families and the individuals requiring care and support need to make informed and considered choices in uncomfortable circumstances, aided by busy health and social care professionals who may not have had the chance to get to know them well and are focused on providing medically appropriate care. The experience can be stressful, and individuals and their loved ones may not always have the luxury of long, open discussions.

A basic ethical principle of health care is informed consent: that an individual is entitled to know the risks and benefits of a given treatment or care option, and to decide whether they want to pursue it, free from any form of coercion.

Sometimes, because of illness, an individual may be incapable of making a decision, and their loved ones may have to decide for them as their legally determined designated substitute decision maker. That person's role is to carry out wishes expressed in advance, or, if these are absent, make judgments about what the individual requiring care would have wanted.

Occasionally, despite everyone's best efforts, these choices don't reflect what the individual, with the benefit of full information and sufficient time, would have chosen. In these cases, it's hard to tell whether the principle of informed consent has been fully satisfied.

For this reason, it's important for all Canadians, and especially older Canadians who are most likely to be engaged in making such decisions for themselves and/or loved ones, to inform themselves about their health and care issues and think about and discuss their values, treatment and care options, and preferences well in advance.

This includes the management of chronic conditions, what kind of supportive or life-saving care is acceptable in the event of a terminal illness or condition, and where a patient will live and who will look after them if they are no longer able to live independently.

Advance Care Planning (ACP) is the process by which a person expresses what they wish to take place should they become incapable of consenting to or refusing treatment or personal care, including deciding who will make decisions on the person's behalf if this happens.[170]

The process should include discussions with family members, friends, and other loved ones, and cover a wide range of scenarios and treatments, including end-of-life care, chronic conditions, and long-term care needs. Other people who may be involved include health care providers, and lawyers who can help to facilitate and document the person's decisions in the form of an advance directive.[171]

The evidence is clear that ACP makes a big difference. Studies show that ACP – especially formal programs involving trained facilitators – improves the quality of end-of-life care.[172]

A review of studies found that patients who had an advance care plan in place were less likely to be admitted to an intensive care unit, and those who were admitted stayed there for less time.[173] Some studies even suggest that just having an advance directive in place reduces risk of hospitalization and the chances of dying in the hospital.[174]

ACP also helps to support loved ones in a difficult time. Formal ACP counseling has been shown to significantly reduce stress, anxiety, and depression in family members, and patients and family members who received the counseling were more satisfied in general.[175] Finally research also suggests that ACP may reduce health care costs by avoiding unwanted treatment.[176]

Clearly, every effort must be made to ensure that as many Canadians as possible, particularly older Canadians, engage in timely, comprehensive ACP, and are supported in doing so.

What Are the Issues?

1. Canadians Aren't Sufficiently Informed, Encouraged and Empowered to Initiate and Participate in ACP Discussions

Recent surveys show that many Canadians are either not aware of the need for ACP, or find it difficult to start and sustain the often challenging conversations involved. A 2012 survey found that 86% of Canadians had not heard of ACP, over 80% had no form of written plan, and less than 50% had a conversation with a family member or friend about what health care treatments they would and wouldn't want if they were ill and unable to communicate.[177]

This problem is not unique to Canada. A survey of experts in Australia concluded that country's similarly low uptake of ACP was due in large part to "inadequate awareness, societal reluctance to discuss end-of-life issues, and lack of health professionals' involvement in ACP." [178] The Canadian Bar Association similarly observed that "a reluctance to contemplate and speak about [illness and death] often stands in the way of effective ACP." [179]

2. Health and Social Care Providers Lack the Education and Training to Effectively Facilitate Advance Care Planning

Health and social care professionals play a critical role in initiating and facilitating ACP in a range of settings. As such, engaging in the necessary sensitive conversations with care recipients and their family members, when appropriate, needs to be part of the core skill set of all clinicians. No one profession can be solely responsible for ACP, and all health and social care team disciplines need to be educated and supported to play their role. In addition to formal instruction, health and social care providers require continuing education and practical training.

This is especially important because ACP is not solely about documenting an individual's choices at a given point in time so that later discussions are not necessary. Rather, it's an ongoing process that threads through the continuum of care from primary to acute to long-term care settings, and is the responsibility of every health and social care provider the person encounters.

Individuals, including the severely ill and/or cognitively impaired, need to be fully involved in decision-making to the extent possible, and helped to achieve health literacy and formulate the goals of their care. Providers must also recognize that these goals, along with a person's values and preferences, may change over time.

Given the importance and complexity of the ACP process, special formal and experiential education, ideally starting early in providers' professional development, is required. In many cases, however, professionals have inadequate access to this training.[180]

For instance, a 2014 survey found that just 24% of Canadian primary care doctors felt experienced and comfortable talking with their patients about ACP for illness and end of life care. A further 52% felt somewhat uncomfortable, while 24% reported no experience or comfort. The same report found that as few as 18% of primary care nurses felt comfortable discussing ACP with patients, while 50% were having these conversations despite feeling uncomfortable, and 32% were not discussing ACP at all. A 2009 national roundtable convening a wide range of stakeholders revealed that many health care providers were reluctant to engage in ACP discussions, and emphasized a need for a "culture shift – that should be focused on re-educating the public and health care providers and providing them with the tools they need to do this.[181]

While core ACP competencies for health and social care providers have been identified,[182] there is currently no central resource that provides ACP education materials or standards to which individual providers, health care organizations, or educational institutions can refer.

"24% of Canadian primary care doctors felt experienced and comfortable talking with their patients about ACP for illness and end of life care."

3. Organizations Don't Have Ready Access to Tools, Guidelines, and Best Practices

ACP is most effective when the individual care recipient's decisions are well documented and readily accessible in the full range of health care settings. An ideal health care system would include "a consistent, transferable and seamless mechanism for all care providers to share information about advance care planning and ensure conversations continue throughout an individual's care journey across all care settings."[183]

Hence, every health care organization should have an ACP strategy. Institutions that want to develop or improve an ACP program benefit from knowing what works best based on evidence from other experiences. Institutions' ACP programs should also incorporate quality improvement processes that enhances their ways to support ACP.

At present, while ACP research is constantly progressing, there isn't consensus on the best way to document ACPs, or on how to design medical information systems so the ACP is known to care providers when it's needed most. Nor are there best-in-class evidence-based frameworks that institutions can look to when designing and evaluating an ACP program. These are all significant system-level obstacles to a "consistent, transferable and seamless" ACP regime.

Evidence Based Policy Options to Consider

1. Raising Awareness and Educating Canadians About ACP

Existing, well-studied ACP initiatives have emphasized public outreach in order to "engage capable adults and their families, as is appropriate, in ACP through raising awareness, initiating dialogue about ACP and connecting people to the means of engaging in ACP."[184] A number of groups have organized large-scale, nation-wide campaigns to raise awareness and educate the public about ACP.

For example, Advance Care Planning Canada is a campaign organized by a diverse set of stakeholders. One of its main goals is to increase the number of Canadians who engage in ACP with family and friends by 10%. It includes a well-designed, easily navigable website and engages in outreach to community organizations, the general public, patients with acute and/or chronic illness, families/caregivers, health care professionals, and policymakers. Building on such initiatives, the federal government can be a highly effective partner in awareness-raising over the short, medium, and long term.

In the short term, the federal government can encourage Canadians to access the many existing resources developed by provinces and territories, which range from "how to" guides to straightforward, standard ACP forms (see Table 8). For instance, the federal government's services for seniors portal, www.seniors.gc.ca, could include materials promoting the advantages of ACP in simple, accessible terms, and links to key resources.

In the medium term, the many federal organizations involved in the care of could use their portals and communications to direct older Canadians and their caregivers to ACP resources, and make ACP awareness a clear goal at the service delivery level, supported by the necessary training for all client-facing staff.

Over the longer term, ACP engagement could be emphasized as a clear priority in health care discussions between the federal and provincial/territorial governments, and resources dedicated to the development of a joint promotion strategy around an issue of collective national importance.

2. Supporting Health and Social Care Professional Education in ACP

The federal government can lead the way by putting health care provider ACP training on the agenda in all conversations about national health care delivery and education. In particular, it can emphasize the need for professional bodies to set mutually consistent national standards, and for universities and colleges to align their curricula with corresponding training standards, and support these organizations in achieving these objectives in a consistent and coordinated way.

As it has done with respect to many other critical health policy issues, the government can convene and facilitate discussions between stakeholders involved in health care education. It can sponsor research, e.g., through targeted Canadian Institutes of Health Research grants, to identify effective ACP education strategies and further support ACP education initiatives. In 2002-2003, the Canadian Institutes of Health Research deployed over $19 million in funding for palliative care research studies and capacity building. And as part of the development of the 2007 Canadian Strategy on Palliative and End-of-Life Care, the federal government sponsored and contributed to the creation of an interprofessional ACP education module.[185]

3. Promoting ACP Best Practices:

The federal government is actively involved in promoting and disseminating end-of-life care and palliative care best practices.[186] For instance, the Palliative and End-of-Life Care Unit at Health Canada ensures that these issues are taken into consideration in relevant federal health policy initiatives. The Public Health Agency of Canada (PHAC), through the Division of Aging and Seniors, provides federal leadership and serves as a focal point for information on public health issues related to ageing and older Canadians.

As it does in the area of palliative care generally, the federal government can play a critical leadership role in ensuring that the findings from ACP research and experiences are distilled and shared among health care institutions and practitioners. For instance, in 2008, Health Canada collaborated with two health authorities that had successfully implemented regional ACP strategies to create an implementation guide to help other authorities "develop or enhance their own advance care planning initiatives." [187] Health Canada also helped fund production of a 2009 report on a national roundtable on advance care planning.[188] Expanding the scope and scale of these collaborative activities would be worthwhile, especially with federal leadership, given that recent surveys show there is still much to be done to make sure all Canadian and care providers can become more routinely familiar and active with ACP principles and practices.

Table 8: Selected Provincial/Territorial ACP Resources Available to the Public

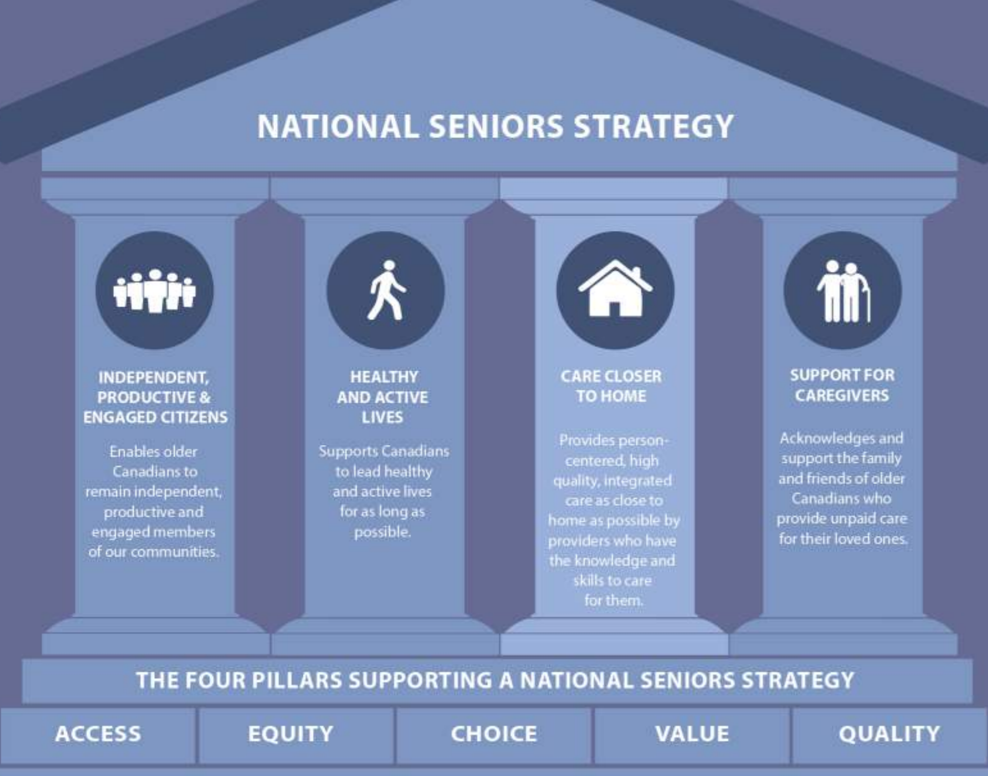
Jurisdiction	Resource	Description
British Columbia	Making Future Health Care Decisions	Includes "My Voice: Expressing My Wishes for Future Health Care Treatment," the B.C. Government's user-friendly guide to advance care planning.
	Comox Valley, "Advance Care Planning"	Dedicated website explaining need to ACP and linking to helpful resources.
Alberta	Alberta Health Services, "Conversations Matter"	Interactive online guide to advance care planning, organized around helping patients to clarify their values and wishes.
Saskatchewan	Regina Qu'Appelle Health Region, "Advance Care Planning"	Contains forms and brochures, as well as details about the Region's ACP information sessions.
	Ministry of Justice & Attorney General, "Planning Ahead"	Detailed memorandum about how to ensure an ACP is effectively documented, with emphasis on legal considerations.
Manitoba	Manitoba Health, "Health Care Directive"	Brief overview of health directives, together with a directive template and accompanying guide.
	Winnipeg Regional Health Authority, "Advance Care Planning"	ACP workbook and educational materials. Also includes resources for health care professionals, including forms, policies, and videos of simulated ACP scenarios.
Ontario	Advance Care Planning, "ACP Workbook – Ontario Version"	Detailed, comprehensive ACP workbook for patients and families, accompanied by easy-to-follow forms.
	Ontario Seniors' Secretariat, "A Guide to Advance Care Planning"	Comprehensive guide to ACP. Also includes a printable wallet card to identify the patient's substitute decision-maker.

Jurisdiction	Resource	Description
Quebec	Curateur Public Québec, "My Mandate in Case of Incapacity	Background and forms to complete a provincial "Mandate in Case of Incapacity."
	Éducaloi, "Mandates in Anticipation of Incapacity"	Overview of provincial Mandates of Incapacity.
Nova Scotia	Nova Scotia Department of Justice, "Personal Directives in Nova Scotia"	Booklet explaining personal directives, including a simple checklist.
New Brunswick	Public Legal Education Information Service of New Brunswick, "Powers of Attorney"	Overview of powers of attorney and testamentary planning in general.
Prince Edward Island	Health PEI, "Health Care Directives"	Short summary of health care directives, accompanied by a form with explanatory notes.
	Health PEI, "Advance Care Planning"	Advance care planning workbook, including reflective writing exercise on values and beliefs. Also has links to a number of educational resources.
	Community Legal Information Association of PEI, "Health Care Directives"	Plain language overview of health directives and the legal process for obtaining one.
Northwest Territories	Northwest Territories Health & Social Services, "Personal Directives: Choosing for the Future"	Brief guide to personal directives, as well as sample directives.
Yukon	Yukon Health & Social Services, "Advance Directives"	Booklet explaining advance directives, as well as simple checklist for required steps.
Nunavut	Nunavut Department of Family Services, "Guardianship"	Explains services available to protect adults who are unable to make care decisions for themselves.

SECTION 3

THE THIRD PILLAR

Care Closer to Home



PILLAR 3: CARE CLOSER TO HOME

ENSURING OLDER CANADIANS HAVE ACCESS TO PERSON-CENTERED, HIGH QUALITY, AND INTEGRATED CARE AS CLOSE TO HOME AS POSSIBLE BY PROVIDERS WHO HAVE THE KNOWLEDGE AND SKILLS TO CARE FOR THEM

Currently older Canadians constitute about 16% of our population, but account for nearly half of our health and social care systems costs. Medicare, our national health insurance system for doctors and hospitals, was established over 50 years ago when the average age of a Canadian was 27 and when most Canadians didn't live beyond their 60s. Our population has changed yet our health care system has not fully adapted to meeting the needs of an ageing population. The majority of Canadians now see access to supportive and palliative care in or close to their homes, and a robust home care system, as top national priorities. We now need to focus on strengthening our Canada Health Act and the Canadian Health Transfer to ensure Canadians can feel confident that our health care system will be ready to meet their needs.

To ensure current and future providers will have the knowledge and skills needed to provide Canadians the right care, in the right place, at the right time by the right provider, our national educational and accreditation bodies for all caring professions including doctors, nurses, social workers should mandate training around the care of the elderly in the same was as they do for other age groups such as children.

The Federal Government and the Federal Ministry of Health can work with Canada's provinces, territories to enable this pillar of activities in a variety of ways.

- **Ensuring Older Canadians have Access to Appropriate, High Quality Home and Community Care, Long-Term Care, Palliative and End-of-Life Services**

  Ensuring older Canadians have access to high quality home and community care, long-term care, palliative and end-of life services as well as medications when and wherever needed, can become a focus and priority of a new Canada Health Transfer, that ties increases in federal support to expected performance improvements. Read more on this opportunity in Evidence Brief #8.

- **Ensuring Older Canadians have Access to Care Providers that are Trained to Specifically Provide the Care they Need**

  Ensuring that Canadians have access to care providers from all professions that are trained to specifically provide the care older Canadians will need, in a culturally sensitive way, is an area that our national educational and care accreditation bodies can be encouraged to prioritize. Read more on this opportunity in Evidence Brief #9.

- **Developing Standardized Metrics and Accountability Standards to Enable a National Seniors Strategy**

  Ensuring that we stay on track in retooling our health care systems to meet the needs of an ageing population will require that Canadians, along with our health system funders and planners, have access to high quality information that can help us track our performance in meeting our collective goals. Establishing national metrics, information collection and reporting systems through agencies like the Canadian Institutes for Health Information (CIHI), can allow us to link funding to performance and better support all areas of the nation in meeting our collective goals. Read more on this opportunity in Evidence Brief #10.

Evidence-Informed Policy Brief # 8

Ensuring Older Canadians have Access to Appropriate, High Quality Home and Community Care, Long-Term Care, Palliative and End-of-Life Services

National Seniors Strategy Evidence Informed Policy Brief # 8

Ensuring Older Canadians have Access to Appropriate, High Quality Home and Community Care, Long-Term Care, Palliative and End-of Life Services

Setting the Context:

Supporting older Canadians to age in their place of choice depends on having access to appropriate care services when and where they need them. Over the last decade, there has been a significant reorientation of health care delivery from institutional-based settings, like hospitals and long-term care (LTC) homes, toward more home and community-based settings (see Figure 3 for Conceptual Framework for Home and Community Care in Canada).[1] Despite this shift, there is a general recognition that we continue to inadequately meet the home and community care needs of older Canadians.

Statistics Canada recently estimated that while **2.2 million Canadians receive home care, 15% of them still reported having unmet needs.**[189] These figures are likely underestimated given that a number older Canadians who could benefit from the support of government-funded home care services don't know how best to access them or choose not to access them because they don't feel it would adequately meet their needs. Furthermore, it has been demonstrated that there are still many older Canadians who are prematurely institutionalized in LTC homes due to challenges in accessing even basic home and community care supports or other more general appropriate support services. Indeed, the lack of adequate home and community care services that can support individuals' activities of daily living (ADLs) is not only a strong predictor of institutionalization, but also an extremely strong predictor of overall utilization of health care services for older adults.[190,191,192]

Across Canada there have been varied approaches to bridging the unmet needs gap to support older Canadians' health and ADL needs in their homes. One of the latest promising approaches to address access to care issues are community paramedicine models, especially in more rural and remote communities (See Case Study 1[193,194]).

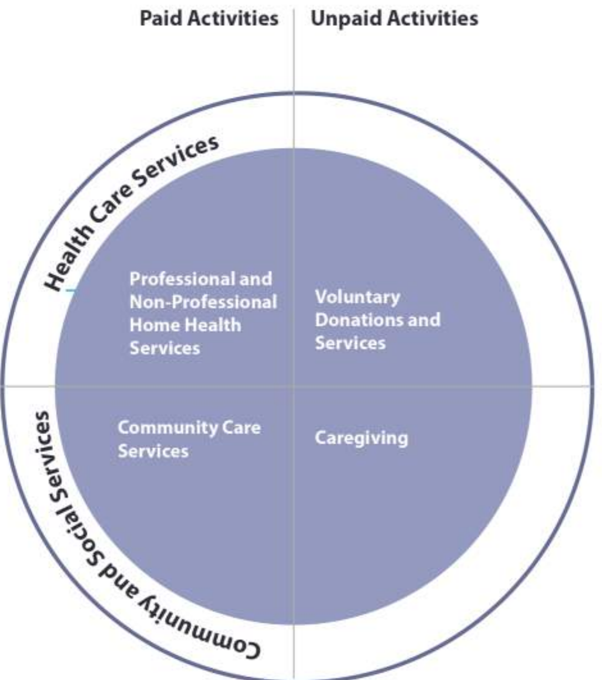
Case Study 1. Innovative Approaches to Home and Community Care with Community Paramedicine

While waiting for placement in a long-term care home, older adults make frequent contact with the health care system and have high rates of emergency department use. As a result, in the rural town of Deep River, Ontario, the County of Renfrew Paramedic Service launched a unique community paramedicine program with funding from the Champlain Local Health Integration Network (LHIN) to support older adults who are eligible for or awaiting a long-term home placement to stay in their own homes longer. Through this cost-effective program, paramedics in association with other community partners, developed a system to provide 24-hour flexible and proactive supportive and enhanced home-based primary and community care services to these older adults – with impressive results. The program reduced overall ED and hospital utilization, and improved the health status of individuals such that it delayed or even completely avoided admissions to the local long-term care home. This paramedicine program is not the first or last of its' kind, with similar initiatives across the country.

[1] For the purposes of this brief, we're considering the paid activities referred to in Figure 4. See Caregivers brief for unpaid home and community care information.

That the proportion of older Canadians is growing, and many of them are living far longer with more complex and often inter-related health, social and functional issues than previous generations, means that our ability to meet the rapidly growing needs for home and community care services is becoming increasingly challenging. Additionally, understanding the growing need for more robust home and community care services must be understood in the context of what legitimate needs do and will exist for institutional-based care such as assisted living, acute and LTC services. Only by understanding the evolving care needs of Canadians across all aspects of system will we be able to avoid the provision of inappropriate and often more costly care for older Canadians.

Figure 3. Conceptual Framework for Home and Community Care in Canada[195]



Avoiding inappropriate LTC admissions and inappropriate stays in acute care settings amongst older Canadians has become a significant policy and health services research focus for health care systems across Canada. It is estimated that 15% or, 7,500 acute care hospital beds per day in Canada, are being occupied by individuals designated alternative level of care (ALC) patients.[196] The vast majority of ALC patients are older Canadians who are ready to be discharged from hospitals but for whom no appropriate home and community support or LTC services are immediately available.[197]

Current estimates predict that the **freeing of acute care resources through providing more appropriate levels of care for older Canadians could result in $2.3 billion in annual savings for use elsewhere in the health care system.**[198] Several examples of program and policy interventions targeting ALC issues are emerging throughout Canada. For example, Ontario's Home First policies, which have been adopted in a number of other parts of the country aim to, "identify individuals at high risk for institutionalization in order to provide adequate supports to enable successful transitions back to one's home or for people to remain in their homes in the first place".[199]

Within the first two years of its Home First initiatives, Ontario saw its overall supply of LTC beds decline by 2.7 per cent amongst its fastest growing segment of the population aged 75 years and better. At the same time, demand for LTC declined 6.9 per cent, while the placement rate into long-term care beds declined 26 per cent amongst Ontarians 75 years and better.[200]

While understanding the interface of services across the continuum of care is complex, legislative factors further complicate realizing the potential role of home and community care and LTC services in reducing ALC days. With both home and community care and LTC services considered "extended health services" under the Canada Health Act, they remain completely regulated, organized and funded at the provincial, territorial and, in some instances, municipal levels.[201,202]

The exclusion of home and community care and LTC services from the Canada Health Act has been criticized for the resulting "postal code lottery" of care available for older Canadians in need of these services. Table 9 summarizes descriptions of income based home care services, public expenditure on home care, as well as proportion of individuals over 85 years of age in LTC along with the number of LTC beds by province/territory. We would expect to see that as the proportion of public spending for home and community care increased, rates of LTC placement may be curtailed. That some provinces (e.g. Newfoundland and Labrador) spend a higher proportion on home and community care yet also have higher than average rates of LTC placement, while provinces such as Prince Edward Island spend a very low proportion on home and community care yet also have the highest rates of LTC placement, demonstrates the importance of understanding contextual complexities in health system capacity planning.

While many capacity challenges exist throughout the health care continuum, the unmet palliative and end of life care needs of Canadians run across the continuum of care with respect to home, community, and institutional-based services. Palliative, hospice, and end of life care can be understood as services which, "aim to relieve suffering and improve the quality of living and dying".[203] The Canadian Hospice Palliative Care Association cite that, **"only 16-30% of Canadians who die currently have access to or receive specialist hospice palliative and end-of-life care services"**.[204] Beyond helping individuals to die with dignity and in less discomfort, evidence for the provision and accessibility of palliative care services – be it delivered in the home or an institutional setting – suggests there are significant overall systemic cost savings that could be realized for our health, social and community care systems by providing these services.[205] With the advent of the unanimous ruling by the Supreme Court of Canada that individuals have the right to physician assisted death, we must begin thinking about end of life care service provision in ways we have not before. Future research must be directed toward understanding resource allocation and the systemic implications of providing this service. Currently, no consensus on cost-benefit of physician assisted death exists at the system level. Exploring how to leverage knowledge and evidence from other jurisdictions where physician assisted death has been part of the continuum of care (e.g. The Netherlands, various U.S. States, and Belgium) may also go some way to inform capacity planning.

Across all levels of health care service delivery, we must recognize that access to appropriate and high quality care for older Canadians not only directly impacts the quality of life of individuals but can also deliver significantly improved patient and system outcomes and costs.

Table 9. Income-based Home Care Service Delivery Models in Canada & LTC Use Per Province/Territory

Province/ Territory	Description of Income-Based Model of Funding where In Place[206]	Public Expenditure on Home Care ($ millions), percentage of total as of 2012 [207]	Proportion of population over 85 yrs in LTC by province (male %, female %)[208]	Total number of publically funded LTC beds by province (N)[209]
British Columbia	Home support is income tested with the exception of two weeks post-acute home support or for palliative care.	$721, 4.5%	(10.6, 17.3)	24,616
Alberta	Assessed professional case management, professional health, personal care and caregiver support services are provided without charge. A consistent provincial process and fee schedule is under development to determine client charges for home and community support services.	$402, 2.4%	(13.1, 19.7)	14,654
Saskatchewan	For meals, homemaking and home maintenance, fees are charged (according to income testing) to clients after their first 10 units of service in a month. Subsequent units of service are charged based on client's adjusted monthly income.	-	(14.7, 21.5)	8,944
Manitoba	-	$290, 5.8%	(14.5, 24.6)	9,833
Ontario	-	$1,988, 4.4%	(14.3, 24.4)	75,958
Quebec	-	$1,407, 5.4%	-	46,091
New Brunswick	Income testing for long-term supportive and residential care services according to net income. Client contribution required based on income testing for home support services through Social Development.	$187, 6.4%	(15.8, 24.1)	4,391

Province/ Territory	Description of Income-Based Model of Funding where In Place	Public Expenditure on Home Care ($ millions), percentage of total as of 2012	Proportion of population over 85 yrs in LTC by province (male %, female %)	Total number of publically funded LTC beds by province (N)
Nova Scotia	Has no fees for clients whose net income falls within or below the designated Home Care Nova Scotia client income category or who are in receipt of income-tested government benefits (e.g., Guaranteed Income Supplement, Income Assistance, Family Benefits). No fees charged for nursing services or personal care services provided by RNs or Licenced Practical Nurses or for physician services provided through Medical Services Insurance.	$196, 5%	(10.4, 20.9)	5,986
Prince Edward Island	-	$13, 2.3%	(21.3, 32.8)	978
Newfoundland	No income testing for those requiring professional health services or short-term acute home support but applies a financial assessment for long-term home support services.	$136, 5.6%	(22.5, 33.3)	2,747
Northwest Territories	-	$4.6, 1.6%	-	-
Nunavut Territory	-	$7.8, 2.8%	-	-
Yukon Territory	-	$4.5, 2.2%	-	-

What Are the Issues?

1. A Lack of Support Services for Activities of Daily Living (ADLs) Negatively Impacts an Individual's Health, Causes Additional Stress for Family and Friends, and has Systemic Cost Implications

While health care specific services are extremely important, evidence suggests that older adults who have inadequate access to the necessary home and community care supports for activities of daily living (ADLs) – such as personal care, cooking, cleaning and transportation – ultimately end up using more health care resources.[210] A Canadian study found that 25% of older adults have at least one unmet need related to their ADLs, with the most common of those being housekeeping and transportation[211] (see the Affordable Housing and Transportation brief for more information on unmet transportation needs). Much of this care is what family members, friends, caregivers and lower paid and less regulated health care professionals like personal support workers or care aides provide. For families and friends of older Canadians, meeting needs that are under-supported by home and community care can lead to increased caregiver burden, stress and anxiety.

Furthermore, unmet needs can present significant out of pocket costs to friends and family. For example, the Canadian Hospice and Palliative Care Association estimate that 25% of palliative care costs associated with providing care in the home are covered by family members.[212]

Negative outcomes associated with unmet care needs have far reaching effects. Most immediately, individuals with unmet home care needs are more likely to experience injuries (specifically increased risk of falls), depression, reduced morale, lower self-reposted health status, feelings of decreased control, smaller social networks and an inability to prepare food. It has been well-document that having unmet needs and having to depend on others for one's ADLs have been shown to result in more visits to the doctor as well as significant increases in emergency department visits, hospital admissions, ALC days, institutionalization, overall morbidity and mortality, and premature death.[213,214,215,216,217,218] For some specific age-related illnesses such as dementia, the effects of unmet care needs increase the likelihood of an individual's placement into a LTC home, death, and loss to follow-up.[219]

Understanding that supports for daily living are just as important as more clinically oriented forms of home care will be important for anyone considering the current and future provision of home care services. Furthermore, understanding the need to support families and caregivers in order to alleviate caregiver burden whenever possible, will enable the chances that a person will be able to continue ageing in place.

2. Certain Older Canadians are More Likely to Have Unmet Needs

We know that certain groups of older Canadians are more likely to have unmet home and community care needs due to a variety of social and economic determinants that limit their access to these services. According to the evidence, groups more likely to have unmet needs include the following:

- **Low Income Older Canadians –** Older Canadians cited their ability to pay as the biggest factor contributing to their access to the home and community care support they need. Up to 63% of those reporting unmet needs attributed this to personal circumstances such as their inability to pay.[220,221]
- **Caregivers –** According to a Statistics Canada study, 38% of individuals reporting unmet home care needs are caregivers themselves. [222]
- **Older Women –** Unmet needs among older Canadian women is almost double that of older Canadian men. [223]
- **Immigrants –** According to a Statistics Canada study, 20% of those indicating unmet needs for care are immigrants to Canada.[224]
- **Our oldest Canadians –** The likelihood of having unmet needs doubles between ages 65-70 and 85 years and better.[225]
- **Older Adults with Physical Limitations –**29% of individuals indicating they have mobility issues also reported having unmet home care needs compared to 4% of older adults reporting no physical limitations.[226] Meanwhile, 10% of severely disabled older adults reported having unmet home care needs compared with 1% reporting no disability.[227]
- **Older Adults Who Live Alone -** Individuals living alone report twice the unmet need compared to those living with others.[228]

Given the significant disparities in reporting unmet need, future home care policies must ensure the provision of supports for older Canadians who are particularly vulnerable. Enabling individuals to age in the place of their choice will often save the health and social care systems more money than the associated costs of having them pre-maturely placed in institutional care settings.

3. There is Currently No Clear Capacity Plan to Address Home and Community Care and Palliative Care Needs of Older Canadians

Despite the fact that we know that the number of Canadians 65 and older will double over the next twenty years – and those 85 and older will quadruple – there is no province or territory that has a clear capacity plan to meet the evolving home and community care and palliative care needs of our ageing population. Work must be undertaken to set minimum national standards for home and community care, long-term care and palliative care services. Though challenging at a national level, such work will enable provincial and territorial efforts toward the development of more unifying health human resources strategies and the development, expansion and evolution of services that better enable the provision of care closer to home.

While home, community and palliative services are not encompassed in the Canada Health Act, and are therefore considered 'extended health services', the federal government still has an important role to play in enabling capacity planning. Health Canada's role in home care human resources is outlined as, "support[ing] and conduct[ing] research and policy analysis related to home care labour force issues" including: better understanding supply and demanded issues, evolving education and training needs, recruitment and retention strategies and other demographic work force trends.[229] To start, quantifying the actual service needs regionally and working together towards setting national capacity planning goals, standards, targets and benchmarks would leverage the federal governments' leadership abilities to accomplish more than enabling research and policy analyses in this space.

Evidence Based Policy Options to Consider

1. Federal Leadership in Sharing Best Practices and Supporting the Establishment of Common Standards, Targets and Benchmarks for the Provision of Home and Community, Palliative and Long-Term Care Services

Given that this area of health services provision is becoming of growing importance for Canadians and health system sustainability, the federal government should help play an important leadership role as a jurisdictional convener to explore and support the development of common policies and practices and programs of research in these areas. Supporting the spread of innovative solutions and best practices that better enable the provision of care closer to home will not only allow more Canadians to age and die in the place of their choosing, but will also enable broader system savings that can further ensure its overall sustainability. Working with all provincial and territorial partners could foreseeably result in common basic standards, targets and benchmarks which allow jurisdictions to more easily plan health system capacity and compare or benchmark their performance.

2. Enabling National Standards, Targets and Benchmarks in the Provision of Home and Community Care as well as Palliative Care Standards with future Canada Health Transfers (CHT)

In 2004, the Government of Canada's Action Plan on Health specifically earmarked Canada Health Transfer (CHT) funds to address wait time issues across the country with the support of the Wait Times Reduction Fund. National standards, targets and benchmarks were established in partnership with the provinces and territories around this common issue of national importance. In exchange for designated CHT funds, the provinces and territories committed to publically reporting their wait times data and continually work on strategies both individually and collectively that helped them to meet agreed upon targets.

There has been a growing call for the consideration of using a new CHT agreement as a vehicle for incenting targeted plans for health service provision in the areas of home, community and palliative care. Should this approach be considered, it will require committed leadership by the federal, provincial and territorial governments to work together to set national standards, targets and benchmarks with comparable and meaningful measures that can clearly illustrate progress. Given that the federal government has demonstrated previous leadership in shaping the delivery of health services across Canada, the ageing of the population presents another opportunity to address the growing national issues of ensuring that all Canadians can get access to essential home, community and palliative care services.

Evidence-Informed Policy Brief # 9

Ensuring Older Canadians have Access to Care Providers that are Trained to Specifically Provide the Care they Need

National Seniors Strategy Evidence Informed Policy Brief # 9

Ensuring Older Canadians have Access to Care Providers that are Trained to Specifically Provide the Care they Need

Setting the Context:

While there are many personal and environmental factors which impact healthy ageing, having available and appropriate health, social, and community care providers with the knowledge and expertise needed to care for older Canadians is essential to support us all as we age. Unfortunately, there still exist no mandatory training requirements around providing care for older adults for virtually all future health and social care professions in Canada. As a result, many of our current core and postgraduate training programs for health and social care professionals provide limited exposure towards understanding and managing the specific issues that are related to caring for an ageing population.

Care providers represent a large variety of health and social care professionals that do not merely include doctors and nurses, but also occupational therapists, physiotherapists, pharmacists, social workers, recreational therapists, personal support workers and others. In a recent assessment conducted on behalf of the Council of Ontario Universities of the core training curricula of 76 training programs for health and social care professionals, only half indicated having, "a required seniors' care, gerontology, or geriatrics course".[230] The survey also demonstrated that only half of the programs reported offering, "a required clinical or practicum experience with a focus on seniors' care, gerontology or geriatrics".[231] Despite the Ontario-centricity, the report accurately reflect the variability and general lack of standardized training requirements related to the care of older adults that exists across Canada. Furthermore, these findings illustrate that training in the care of older adults in Canada is lacking across the spectrum of care professionals, and not merely limited to physicians and nurses.

Box 1. International Case Example – Access to Geriatricians in Iceland and Canada

Iceland

Population: 300,000

Individuals > 70: Approximately 30,000

Number of Practicing Geriatricians: 17

Geriatrician to > 70 Population Ratio: 1:1,700

Canada

Population: 35 million

Individuals > 70: Approximately 3.75 million

Number of Practicing Geriatricians: 242

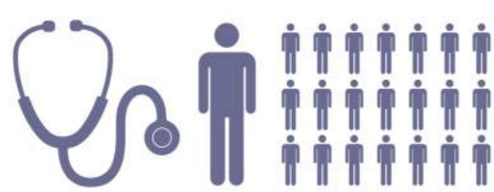
Geriatrician to >70 Population Ratio: 1:15,495

Most concerning, however, is the fundamental mismatch that exists between our current training provisions and the fact that older Canadians are becoming the greatest users of our health care system. Therefore, ensuring that Canada has a health human resources strategy to meet these and other demographic imperatives will be essential.

What Are the Issues?

1. Canada Does Not Have a National Health and Social Care Human Resources Strategy to Meet the Needs of Our Ageing Population

Current Canadian demographic trends estimate that the numbers of older Canadians 65 and better and those 85 and better will respectively double and quadruple over the next two decades. While we share similar demographic imperatives as others, compared to other countries around the world, Canada noticeably falls behind in both recognizing and preparing its health and social care professionals to meet the growing need for geriatrics expertise.



When looking at the supply of physicians with training in geriatrics for example, both larger and smaller countries such as the United Kingdom and Iceland, also with universal health care systems have prioritized the training and hiring of geriatricians (see Box 1 for an Iceland vs Canada Comparison[232,233,234]).

While Canada has 1 certified geriatrician for every 15,495 older Canadians, the disparity becomes even more pronounced at the provincial and territorial level – with 4 provinces and territories having either zero or one geriatrician to serve their entire population.[235] Another way of illustrating the existing health human resources mismatch can be understood by looking at the ratio pediatricians to geriatricians. For example, in 2013, there were approximately 129 geriatricians serving 2 million older adults in Ontario, while at the same time, 1,641 pediatricians served 2.2 million children.[236] Whether this may or may not be the appropriate health human resource distribution, we know that the number of older adults will exceed the number of children in the coming decades and planning for this shift is essential. There is clear evidence that geriatricians play an extremely important role in supporting older adults to remain healthy and independent for as long as possible.

While caring for those with more complex and inter-related health and social care needs, geriatricians often provide more appropriate, often cost-effective care. The evidence suggests that geriatric assessments in hospital have the ability to, "reduce short-term mortality, increase the chances of living at home at one year and improve an older person's physical and cognitive function".[237] With each of these benefits having real cost savings implications to the health system as a whole, there exist good reason to determine collectively what health human resources and training strategies need to be in place to meet our growing need for geriatrician services as we age.

Understanding why a shortage of geriatric specialists exists is multifactorial. While geriatricians have traditionally remained some of the lowest paid specialists until recently, the alarmingly anemic focus on geriatric medicine in medical school curriculums as well as residency training programs is more likely to blame. No Ontario medical school, for example, currently offers core training in geriatrics, but every school offers core training in pediatrics.

It is ironic that while the vast majority of graduates will enter fields predominantly serving older and not younger patients, pediatrics and not geriatrics remains a core part of current curriculums.[238] Indeed, a lack of exposure to the care of older adults has likely contributed to the low number of medical graduates considering and thus entering formal geriatric medicine training programs. Given the increasingly recognized unique needs of older adults seeking medical care, this should be a major concern when most graduating physicians receive little or no exposure to geriatrics, and far fewer choose to practice this specialty.

A lack of geriatricians, however, is only part of the larger health human resources and training challenge related to meeting the future care needs of older Canadians. Across the health care system and within our communities, other health and social care professionals interact with older Canadians with a much higher frequency and regularity than specialized physicians such as geriatricians. However, as previously mentioned many professional training programs have no stated mandatory training requirements around care of the elderly. Table 10 illustrates this finding for occupational therapy, pharmacy, nursing and paramedicine; although, many others could have been included. In addition to all health and social care trainees being provided with limited exposure to geriatrics, they are also likely to receive limited exposure to care settings like long-term care, rehabilitation and home and community care settings, where older adults are the main recipients of care.

Table 10. Summary of Professional Accreditation Bodies, Competency Statements Sources and Requirements for Training Around the Care for Older Canadians

Profession & Accrediting Body	Competency Statements	Geriatric Training as a Requirement?
Occupational Therapists; Association of Canadian Occupational Therapy Regulatory Organizations	Essential Competencies of Practice for Occupational Therapists in Canada (3rd Ed.)	• Expectation for competency across the lifespan • No specific geriatrics competencies required
Pharmacists; National Association of Pharmacy Regulatory Authorities	Professional Competencies for Canadian Pharmacists at Entry to Practice: Second Revision	• No specific geriatrics competencies required • Across the lifespan not explicitly stated
Registered Nurses; Canadian Nurses Association	Framework for the Practice of Registered Nurses in Canada[239]	• No specific geriatrics competencies required
Paramedics; Canadian Medical Association (CMA)	1) Guiding principles for national entry-level competency profiles used in the CMA conjoint accreditation process 2) Guidelines for paramedic programs on the use of the Paramedic Association of Canada's 2011 National Occupational Competency Profile in the CMA conjoint accreditation process 3) Revised advisory to paramedic programs re: revision to competency profile	• No specific geriatrics competencies required • No specific geriatrics competencies required • No specific geriatrics competencies required

Adapted from McCleary, Boscart, Donahue & Harvey (2014)[240]

As Table 10 illustrates, national accreditation standards, those that influence the curriculums delivered in our nation's training programs for health and social care professionals, apparently do not adequately emphasize training in the care of older adults. Given this lack of emphasis in national accreditation standards, many of our publicly funded training programs have not prioritized this training in their curriculums. Nevertheless, developing an adequately trained workforce that will have the knowledge and skills needed to care for an ageing population needs to become a national priority. Furthermore, encouraging and supporting the development of continuing educational opportunities for professionals that focus on developing further knowledge and skills in this area needs to occur as well. Indeed, improving the knowledge, skills, and confidence of our health and social care workforce to care for our ageing population will further ensure that our aim of providing the right care, at the right time, in the right place will be achieved.

In conjunction with a lack of appropriately trained health care professionals, we have a general lack of sufficient workforce numbers to adequately meet the needs of our older population. Our health and social care sector is one with the largest number of occupations facing human resource shortages. Therefore, in addition to curricula changes, sufficient numbers of professionals will be required – in particular geriatricians, geriatric psychiatrists, family physicians, including those with additional training in the care of the elderly, nurse practitioners, nurses, physician assistants, social workers, pharmacists, therapists, paramedics, and personal support workers. Continuing to support the development of team-based care environments will also be integral to promoting the interprofessional care that frail older adults particularly benefit from. And with an ageing workforce[241], ensuring that barriers to training and adequately compensating specialists specifically trained in the care of the elderly will be just as important as ensuring that our nurses and personal support workers, upon who much of the care for this population will depend, are valued and supported.[242]

Evidence Based Policy Options to Consider

1. Develop a National Health Human Resources and Education Strategy to Meet the Needs of Our Ageing Population

The planning and delivery of health and social care services is largely a provincial and territorial responsibility while the training curriculums for our regulated professionals are largely guided by national accreditation standards developed by professional colleges and societies. All told, there clearly exists a disconnect between health human resource training and employment strategies at both the regional and national levels. As a result, there clearly exists an opportunity for the provinces and territories to partner with the federal government to understand and collectively plan to address current and future health human resources issues. While our governments are also not in a position to create mandatory training requirements, they still should be welcomed to recommend the emphasis on appropriate geriatrics knowledge and skills acquisition in entry-to-practice and continuing professional development programs – especially when the training and employment of Canada's health and social workforce is largely funded by the taxpayers.

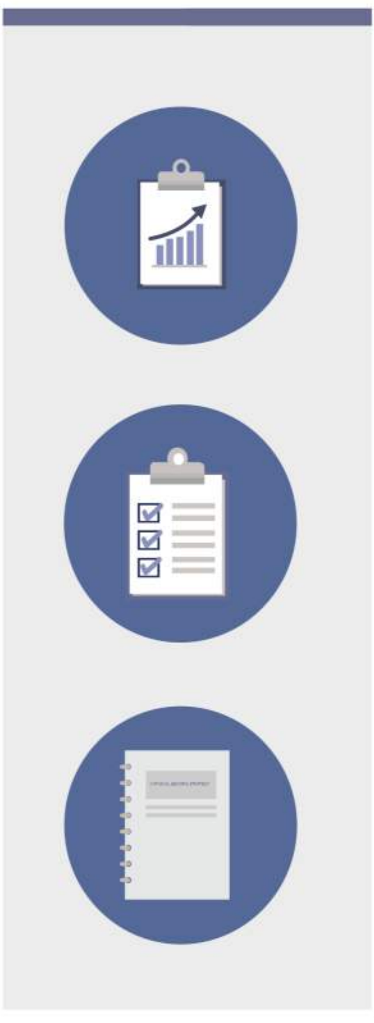
Evidence Informed Policy Brief # 10

Developing Standardized Metrics and Accountability Standards to Enable a National Seniors Strategy

National Seniors Strategy Evidence Informed Policy Brief # 10

Developing Standardized Metrics and Accountability Standards to Enable a National Seniors Strategy

The availability and accessibility of high quality performance information will be vital to measure, monitor and report on how well we are advancing the goals established as part of a National Seniors Strategy. Currently, however, there is no established set of common indicators and metrics that are routinely used to monitor our performance as a nation in comparison with others or internally between our provinces and territories.



In areas where measures do exist, such as within health care, they are not fully harmonized within and amongst provinces, territories, sectors and providers, making it challenging to develop comparisons around performance and to establish even baseline standards. Without this information, it is difficult to hold system players accountable around the delivery of high-quality, evidence-based care, services and supports for older Canadians and those who care for them. Indeed, the challenge becomes clear when we realize that we can't monitor what we don't measure.

Currently, the metrics we have available focus on our systems and services as they have been previously designed and prioritized. For example, our health care system has previously prioritized acute, episodic care for single conditions dealt with primarily in institutional-settings, and thus the development of metrics that examine our performance around these areas. We have not, however, developed metrics that adequately examine the growing complexities related to caring for older and more complex patients in these settings.

Furthermore, our system performance metrics that try and assess the provision of health care and other services and supports in home and community care settings – the fastest growing segment of our current health care systems - is far more rudimentary and certainly not standardized.

What Are the Issues?

1. There Exists no National Standards, Guidelines or Consensus Around what Appropriately Meeting the Needs of Older Canadians Should Encompass

Although there is a pressing need, we still do not have a national consensus as to what 'good' looks like as it relates to what we will feel represents a society that is 'ageing well' or around the optimal delivery of care, services and supports for older adults and those who care for them.

Indeed, especially when it comes to defining quality care for older adults, we find that even our existing clinical practice guidelines or practice standards rarely take into account the challenges that many older Canadians living with multiple chronic diseases and functional limitations currently face and can even be conflicting at times.[243, 244] A lack of national standards, guidelines or consensus around what appropriately meeting the needs of older Canadians should encompass means that it is difficult to hold systems, providers and citizens accountable to themselves and others.

2. You Cannot Monitor and Improve What You Can't or Don't Measure

At the same time that we don't know what 'good' looks like, it's clear that we are unable to measure and monitor our ability to achieve our aims. Measurement is a key enabler for allowing organizations, systems, as well as the public to assess and understand their overall performance and progress towards achieving their aims. While this sounds straightforward, we know it is also very important to be thoughtful around what we choose to measure, as there can easily be unintended consequences to measuring one outcome measure over another.

A great body of research from the United Kingdom has repeatedly demonstrated that the drive to achieve and demonstrate improvement in government selected indicators for health system performance around areas such as wait times, also created a number of unintended consequences related to 'gaming' the overall system that sometimes led to the worsening of other un-monitored outcomes.[245] This is why it's important to design a set of measures that can provide a 'balanced' view of system performance as well.

Finally, in choosing what we will measure, we need to ensure that the metrics and indicators that we end up selecting reflect our aspirations towards achieving standards of health and well-being for older adults and the future provision of care, services and support. For example, as it relates to the future care of older adults, we will want to ensure we have measures and indicators that better reflect our ability to deliver more integrated and community-based care that today's older and increasingly diverse Canadians want and need.

3. Our Current Research and Innovation Priorities are not Routinely Focused in the Right Areas

The bulk of current research and innovation initiatives are still focused on the old ways of delivering services and care, often forgetting about the growing heterogeneity of our overall population, let alone the growing challenges of effectively meeting the needs of an ageing population.

With a growing recognition that the increasing numbers of older adults in our society are not just more 'chronologically mature' but are also increasingly living with growing rates of hearing, visual, cognitive and functional limitations – it is clear that traditional approaches to developing research and innovation initiatives for them must better reflect their increasingly diverse needs. Indeed, the way we will need to deliver services, care and support for older Canadians will have to occur in ways that often requires a more complex, nuanced, multi-sectoral and context-specific approaches. This will necessitate different research methodologies and approaches to develop and evaluate new and more effective ways of delivering services, care and support. Ensuring that our future research and innovation activities are more inclusive of the intended users in the design, implementation and evaluation phases will further help to ensure their chances of being successful as well.

Evidence Based Policy Options to Consider

1. Establish A Framework for the Development, Collection and Reporting of Enabling Performance Measures and Indicators that Can Promote Shared Accountability in Advancing a National Seniors Strategy

Much literature is devoted to lists of indicators that are or could be measured around assessing the health and well-being of older adults or the provision of care, services and support for older adults. In some areas, no widely accepted measures have been established. Therefore, in order to enable a National Seniors Strategy, the federal government should convene and facilitate the creation of a framework for the development of common metrics and indicators to help monitor progress around common initiatives established to enable the health and well-being of older Canadians. Within the domains of health care, these metrics and indicators should focus around the delivery of care, services and supports across the entire continuum of care, with a particular emphasis on metrics that can assess system integration and transitions. The framework should also encompass metrics that can monitor the different perspectives that providers, individuals and their caregivers may have.

The federal government has already established agencies such as the Canadian Institute for Health Information (CIHI), Statistics Canada and others to collect and analyse information and data relevant to Canadians as a whole. Therefore, it would make sense that these organizations in particular could be given a clear mandate to not only collect data, but also report it back in ways that can allow all levels of government and members of the public to promote a shared or mutual sense of understanding and accountability and thus, responsibility for ensuring that established performance targets are achieved.

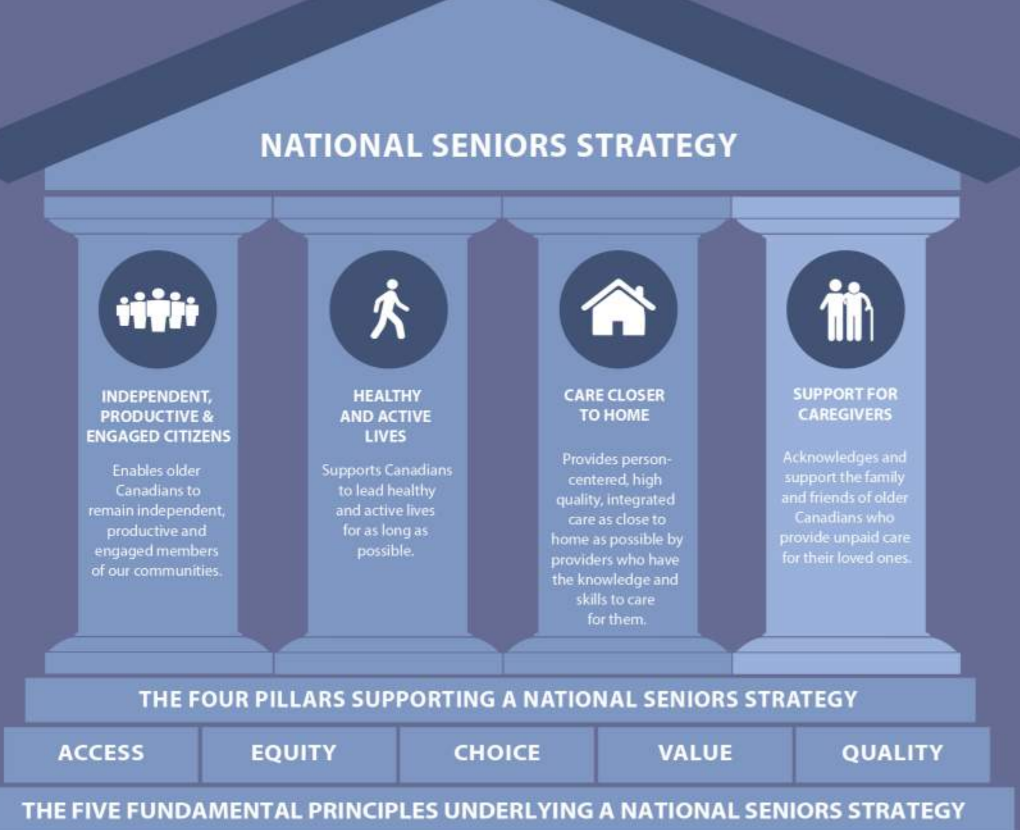
2. Consolidate and Scale Research and Innovation Activities to improve the Health and Well-Being of Older Canadians

In recognizing the demographic and fiscal challenges and opportunities that will come with an ageing population, there remains a clear opportunity to invest further in research and innovation projects that can better address current and future issues. While a number of large funding initiatives (i.e. Age-Well NCE, Tech-Value Net (TVN) NCE, National Initiative for the Care of the Elderly (NICE)) have been created to ageing-related research and knowledge-translation projects, greater consolidation would help to advance learning and spread of innovation. We must ensure that we maximize opportunities to invest in research and innovation activities that support ageing. For example, the recently released Government of Canada's Advisory Panel on Healthcare Innovation's report: Unleashing Innovation: Excellent Healthcare for Canada emphasizes clear opportunities to help focus, consolidate, fund and most importantly, scale innovations that can better address ageing, equity and sustainability for all Canadians.[246]

SECTION 4

THE FOURTH PILLAR

Support for Caregivers



PILLAR 4: SUPPORT FOR CAREGIVERS

ENSURING THAT THE FAMILY AND FRIENDS OF OLDER CANADIANS WHO PROVIDE UNPAID CARE FOR THEIR LOVED ONES ARE ACKNOWLEDGED AND SUPPORTED

In Canada, family and friends are the greatest source of care for older people. As the number of older Canadians with chronic health conditions including dementia increases, more of us will need the support of caregivers. Last year it was estimated that unpaid caregivers provided care that would have cost our system around $30B. The continued dedication and contribution of caregivers sustains our ability to care for older people in the health care system. However, caregivers face an enormous toll on their own health and well-being and their commitment to caregiving has an impact on Canada's economic productivity. Providing appropriate support and recognition to meet the needs of current and future caregivers will not only keep our health care systems sustainable, but will also ensure that our economic productivity as a nation can be improved and strengthened.

The Federal Government can work with Canada's provinces, territories to enable this pillar and associated activities in a variety of ways.

- **Ensuring Older Canadians are Supported in the Workplace**

  Ensuring Canadian employers are informed about and have access to the tools that can help them better support the growing ranks of working caregivers will enhance our overall economic productivity. Recognizing employers who excel in supporting working caregivers can further bring positive attention to this important issue. Read more on this opportunity in Evidence Brief #11.

- **Ensuring Caregivers are Not Unnecessarily Financially Penalized for Taking on Caregiving Roles**

  Ensuring Canadians caregivers are not unnecessarily financially penalized for taking on caregiving roles can be further supported through enhanced job protection measures, caregiver tax credits and enhanced CPP contribution allowances that all have good evidence to support their broad implementation nationally. Read more on this opportunity in Evidence Brief #12.

Evidence-Informed Policy Brief # 11

Ensuring Older Canadians are Supported in the Workplace

National Seniors Strategy Evidence Informed Policy Brief # 11

Ensuring Older Canadians are Supported in the Workplace

Setting the Context:

The past decade has seen a steady increase in the number of older Canadians participating in the workforce, especially since mandatory retirement was formally repealed as recently as 2011. In 2001, approximately **12% of individuals 65-69** were participating in the Canadian workforce – a number that more than doubled to nearly 26% in 2013.[247]

Supporting the participation of older Canadians in the workforce derives many benefits for Canada as whole, including stemming the premature loss of experienced, skilled and knowledgeable workers; further supporting intergenerational knowledge exchange; and driving the overall economic productivity of the country. Indeed, from a macroeconomic perspective, the continued and sustained participation of older Canadians in the workforce beyond the traditional age of retirement may go some way to curtail the some of the negative predicted economic effects of a rapidly growing cohort of boomers who are getting set to retire.[248]

Many common reasons why employers report not considering older Canadians in the workforce have been found to be based solely on myths related to ageing. Specifically, associations of age and overall productivity and cost-effectiveness of older workers; the receptivity of older adults to working in new or challenging environments; the ability to train older workers in new skills.[249]

The federal government has recognized the importance of supporting both employers and older adults who wish to remain in the workforce by collating materials to support both parties in the creation of more 'age-friendly workplaces' (visit www.seniors.gc.ca for more information).

Beyond addressing common workplace myths that surround older workers, encouraging and supporting older Canadians' participation in the workforce recognizes other practical measures like creating more flexible working schedules or adapting physical work environments to accommodate physical or sensory limitations that may be present as well.

While an ageing workforce requires and benefits from special supports to ensure success, a growing number of working Canadians – who are ageing themselves – are also trying to balance unpaid caregiving duties with their work commitments. In fact, it is currently estimated that between **35-60%[250,251] of our workforce or at least six million working Canadians are currently juggling unpaid caregiving duties.[252]**

Despite the economic importance of their continued participation in the workforce, caregivers often end up earning less and foregoing advancements in their own careers than others without these additional responsibilities.

15%
REDUCE THEIR WORK HOURS

40%
MISS DAYS OF WORK

26%
TAKE A LEAVE OF ABSENCE

10%
TURN DOWN JOB OPPORTUNITIES

6%
EVENTUALLY QUIT THEIR JOBS

According to the Canadian Caregiver Coalition, **15%** of working caregivers reduce their work hours, **40%** miss days of work, **26%** take a leave of absence, **10%** turn down job opportunities, and **6%** eventually quit their jobs. While the cost to working caregivers includes lost wages, and decreased retirement income, **19%** further report that their physical and emotional health suffers as well.

For Canadian employers, productivity losses become substantial, with estimations totaling a **loss of 18 million work days per year due to missed days and increased employee turnover.**[253] Indeed, it is estimated that the cost to the Canadian economy from lost productivity due to caregiving responsibilities is **$1.3 billion per year.**[254]

Finding ways to better accommodate the needs of older Canadians including those who may be balancing caregiving duties can result not only in improved workplace productivity, and reduced employee turnover, but an opportunity to retain highly skilled older workers whose experience and expertise are highly appreciated in the Canadian workforce.[255]

There are many employer-led workplace practices that can be leveraged to support older workers and specifically working caregivers (see Table 11). While workplaces that are more conducive to older workers and helping those managing the work-care balance do exist, many still require employees to choose flexible work environments in exchange for less advantageous conditions or salaries.[256] Ensuring that conditions and salaries are supportive of both workplace performance and caregiving roles is of the utmost importance.

Table 11. Inventory of Employer-led Flexible Workplace Practices that Support Employed Caregivers[257]

Paid and Unpaid Leave Practices	
Emergency Caregiving Leave	Employees can request up to five days paid leave to care for a family member or friend Employees can request up to five days paid leave for emergencies which could be health related but not for chronic health issues
Combination of Leave	Employees can request to use a combination of leave (personal/family, vacation or sick leave) to help care for a family member or friend
Personal/Family Leave	Policies vary within organizations (federally vs non-federally regulated employers). Non-federally regulated employment standards vary by jurisdictional legislation Non-federally regulated employees receive a range of 0 to 12 days per year. Some employers combine personal/family leave with sick leave Employees have three floating days (additional paid leave)
Sick Leave	Policies vary within organizations (federally vs non-federally regulated employers). Non-federally regulated employment standards vary by jurisdictional legislation Non-federally regulated employees are provided with a range of sick leave from one day to 26 weeks Employees may request to use sick leave for family illnesses Self-insured medical leave where employees accumulate sick leave credits that they can use when they are ill or injured or in some cases to care for a gravely ill family member or a critically ill child Unlimited sick leave
Vacation Time	Policies vary within organizations (federally vs non-federally regulated employers). Non-federally regulated employment standards vary by jurisdictional legislation Employees may purchase additional vacation time (up to a maximum amount of weeks) Ability for employees to take leave in hours rather than full days (e.g. two weeks' vacation made available in hours over an eight month period)

Bank of Leave	Employees who have exhausted his or her available paid leave can establish a leave bank under which a contributing employee can donate leave to the bank and recipient employees' draw leave to cover time out of the office due to a personal or family medical emergency
Bereavement	Policies vary within organizations (federally vs non-federally regulated employers). Non-federally regulated employment standards vary by jurisdictional legislation Employees may receive a minimum of three to seven days of leave following the death of a family member. Some employers provide a combination of paid and unpaid leave
Compassionate Care Benefits	Non-federally regulated employment standards vary by jurisdictional legislation. Employees could have a range of 8 — 12 weeks of unpaid leave when a family member is gravely ill Employers may provide a top-up benefit for employees bringing their salary back to their full salary levels for part or all of the leave
Leave to Arrange Care	Employees may take up to three days paid leave to make arrangements for care
Leave with Income-Averaging	Employee may request to take leave without pay for a period of a minimum of five weeks and a maximum of three months Employee's salary is reduced over a 12 month period
Leave without Pay	Employees may take up to 12 months of leave without pay. This type of leave can be used for both short and long-term leave Arrangements between employers and staff are discretionary
Family Caregiver Leave	Family caregiver leave provides employees up to 12 weeks of unpaid, job-protected leave for employees to provide care or support to a family member with a serious medical condition. This type of leave is legislated in Saskatchewan, Quebec, and Ontario

Flexible Workplace Arrangements	
Annualized Hours	Allows employees to choose (within boundaries) their days and hours of work for a set period of time The period of time could be weekly (e.g. work 12 hours for three days and two hours for two days); or monthly (e.g. 60 hours one week and 20 hours the next week) This may be ideal for employers with peak hours or seasonal peaks
Compressed Work Weeks/Banking of Hours	Employee works for longer periods per day in exchange for a day off Employees may start earlier or finish later than the normal work day Common arrangements for 40 hours per week could include working an extra hour per day in exchange for one day off every two weeks
Flexible Work Locations	Employees can be transferred to alternate locations across the country and in some cases internationally (depending on the organization) Allows employees to choose their work location or choose to work off-site (e.g. from home)
Flex-time Schedule/ Flexible hours/ Breaks	Employees work a full day but they set a range of start and finish times with their manager. Total hours of work per week are not affected Allows manager to establish core hours where all employees will be at work (e.g. 9:30 am – 3:30 pm) Employers provide flexible breaks where employees can undertake care responsibilities during their lunch hour. Provide preferred parking spaces for caregivers who are caring for a parent or child who are in critical condition and who may need to leave work urgently Employees do not need to take formal leave but can make up the time off required another day (e.g. if an employee needs to leave for an hour during the day, they can stay 30 minutes extra over the next two days) Employers can offer their employees different options for their work assignments (e.g. a truck driver who works long distances could temporarily move to shorter routes to allow him or her to be closer to home)

Job Sharing	Allows two or more people to share one or more positions or duties Job sharing must work effectively for the team and expectations around pay, benefits and holidays must be well-communicated This is an option for employers who do not have many part-time positions available Have colleagues assigned as "back-ups" to files when an employee has caregiving responsibilities and who might need to be absent for a longer period of time.
No Set Schedule	Allows employees to work the hours they choose, no questions asked, as long as work deadlines are met
Part-time/Reduced Hours	Employees can choose to work less than 37.5 or 40 hours per week Arrangements can be on a permanent or temporary basis Hours can be negotiated between employer and employee to ensure coverage at peak workload hours
Phased Retirement	Employees may reduce their working hours or workload over a period of time leading to full retirement Pension legislation allows for partial pension benefits to commence with formal phased retirement Phased approach could be used to train the replacement employee or adjust the redistribution of work among remaining employees
Shift-Work	Employees can work a type of shift-work schedule where a person's work day is split into two or more parts (e.g. employee can start at 4:00 am, provide care responsibilities during the day and do a second shift at night). Employees who work split shifts need to manage their schedule so that they don't get burned out (especially if they are providing care during the day) In some cases where spouses work at the same company, they can stagger their shifts for one spouse to provide care while the other is working Employees can change their work shifts (e.g. can switch from a night shift to a day shift or exchange a Monday shift to Tuesday)

Technology	
Telework/ Telecommuting	Allows employees to do some of the regular work from home instead of going into the office Employer and employees need to establish details such as hours of work, communications between teleworker, co-workers and clients Dependent on employee's roles and responsibilities
Tools/Devices (Hardware)	Depending on employees' roles and responsibilities, employers provide access to technology to enable them to work outside the office include hardware such as a laptop (with remote access), smart phone, tablet, teleconference/videoconference capabilities In special circumstances, allow employees to have their cell phone close by while they are working in case of emergency (e.g. for employees who do not have direct access to a work phone) Loaner equipment available for employee use (e.g. smart phone, laptop, tablet, etc.) Establish policies around technology such as "technology free-time" or "smart phone free-zone" to allow employees to focus on work/ home priorities (e.g. no answering emails from 6:00 pm to 6:00 am)
Tools/Devices (Software)	Web application that enables collaborative work (e.g. sharing of documents, access to intranet portals, document and file management, social networks, extranets, websites, enterprise search and business intelligence) Instant messaging software to allow employees to connect with colleagues regardless of their work location Ability to work from home through an internet platform that allows employees access to their work emails without being connected to the network (e.g. from home through a virtual private network). Provide access to a secure channel to access work emails from employee's mobile device (smart phone or tablet) Employees on shift-work can take advantage of scheduling software that allows employees to log-in to an online account to view and amend their schedule from home. This scheduling software also takes into consideration other variables such as vacations, leaves, etc. Provide employees with online access to HR policies, services, collective agreements, etc.

	Blogs/chat programs to stay connected Applications with EAP information Email notifications, online calendar to indicate regular hours and planned absences of employees
Other Programs and Services	
Employee and Family Assistance Program	Offerings vary by provider but can include referral services for community care options as well as counselling for the employee and/ or their immediate family
Emergency Elder Care	Some employers offer emergency elder care (similar to emergency child care) at minimal cost to the employee (employers cover the cost up to a maximum amount per year) Back-up care is provided as an alternative when regular care is not available
Onsite Seminars/ Lunch and Learns	Varies by employer, but can include internal or external speakers discussing various aspects of caregiving such as community services available or the health of the care provider
Online Networks/ Applications	Online tools that help caregivers access information on programs and services available and connect them to existing networks Health application (and general phone line) that directs users to medical and community supports as well as providing user health assessments and general information Also provides information to employers via plan administrators such as a snapshot on the health of their workforce
Suite of Benefits/ Cafeteria-style Plans	Web-based benefits platforms that connect employees to a menu of services and allow them to manage their own selections that are tailored to their needs and unique situation; similar to the ability of a customer to choose among available items in a cafeteria

What Are the Issues?

1. Older Canadians and Unpaid Caregivers in the Workforce Continue to Face a Number of Challenges

Increasingly, older Canadians are participating in the workforce beyond the traditional age of retirement. Employers, however, have been slow or unsure around how best to accommodate the needs of older workers with policies and practices to support their overall productivity in the workforce. This lack of support often results in premature or forced workforce exit, or early retirement.[258] While there are many recommendations set out by the National Seniors Council for the support of older adults in the workplace[259], supporting older working Canadians who are doubly disadvantaged by caregiving duties must be particularly recognized. Comprehensive evidence supports that working caregivers are at increased risk of negative psychological, social, and health outcomes due to the burden of balancing their work-care responsibilities. [260,261]

It follows that the benefits of paid employment also go beyond providing income and also plays a large role in providing opportunities for caregivers to obtain a form of respite for themselves, to belong to a social network and to experience personal fulfillment.[262] Rigid work environments which do not recognize that work-care balance is essential to caregiver wellbeing – and hence continued work-care participation – are therefore neglecting benefits of employment for Canadians beyond merely providing incomes.

2. Caregivers Unfairly Forego Salary and Workplace Advancement in Order to Maintain their Caregiving Duties

It is well evidenced that working caregivers often have lower annual incomes, forego career advancement opportunities and take early or involuntary retirement due to their caregiving roles compared to non-caregiving counterparts.[263,264,265] While this in and of itself is an issue, lower wages and slowed career advancement are compounded by the potential for caregiving responsibilities to present significant out of pocket costs to caregivers.[266]

In a Canadian study on caregiver burden, over 38% of participants indicated that, "their family or they had to give up necessities because of the expense to provide care".[267] Taken together, reduced disposable income also impacts the ability of caregivers to save for their own eventual retirement.

A lack in their own ability to save will eventually result in a heavier reliance on federal and provincial benefits programs which will in turn be under-supported due to reduced extended health and other benefit contributions usually contributed to over the course of a career.[268] It is clear that it is in the best interest of both governments and employers to help support their working caregivers for as long as possible to ensure they do not feel disenfranchised and that they feel enabled to continue to participate in the workforce to the best of their abilities for as long as they wish.

3. Canadian Employers Lack Clear Guidance on How to Support Older Workers and Working Caregivers

The recent federally sponsored Employer Panel for Caregivers report acknowledged that Canadian employers indicate a clear lack of knowledge around how best to support older Canadians and caregivers in the workplace.[269] Participants indicated that the main barriers for employers in providing support for working caregivers includes: lack of awareness, the nature of certain jobs, and a lack of leadership and support to advance best practices and supports.[270]

A lack of communication among employers and employees was also considered among the major barriers to supporting working caregivers. Fostering a workplace culture that views older workers and caregiving positively must include providing clear information about employer guidelines, policies, sources of information on best practices to support older workers, caregiver benefits available, and leadership and training opportunities which encourage flexible work environments.

Evidence Based Policy Options to Consider

1. Creating National Standards or a Framework to Support More Flexible Working Environments for Older Workers and Caregivers

Addressing inequities among older workers and caregivers is an issue that must be supported by both the federal and provincial/territorial governments and Canadian employers themselves. As expressed by Canadian employers in the Employer Panel for Caregivers[271], support and guidance is needed to successfully support working caregivers in the workforce. The federal government is in a position to support the creation of national standards for workplace inclusivity/participation of older workers and caregivers. In addition to the many recommendations set out by the National Seniors Council for the support of older adults in the workplace[272], the federal government should consider advancing those along with the recommendations made within the Employer Panel for Caregivers report using the latter's framework for positive action:

- **Developing Standards for Assessing the Needs of Older Employees –** Doing so will better support employers to address the knowledge gap between Canadian employers and older employees around how best to support them in the workplace.
- **Engaging Employers to Increase Awareness of the Organizational and Employee Benefits of Supporting Older Workers and Working Caregivers –** Helping employers understand the business case for supporting older workers and caregivers in the workforce (e.g. potential cost savings, recruitment and retention etc.) can better encourage and spur activity in this area.
- **Supporting the Understanding of Current and Needed Resources –** Allows access to necessary information about company policies and guidelines around supporting older workers and caregivers to be addressed but also enables the identification of existing gaps in support.
- **Leading and Managing –** Encourages the need for leadership training and education to foster an 'age-friendly' workplace environment that positively views older workers and caregiving responsibilities.
- **Encouraging Flexible Approaches to Supporting Older Workers and Caregivers –** Acknowledges that not all employee caregiving responsibilities and the needs amongst older workers look the same and that each may require unique ways of addressing identified needs (e.g. making physical adaptations to a workplace, providing support for acute vs. episodic care duties).

2. Federal Recognition of Employers with Best Practices for Engaging and Supporting Older Workers and Caregivers

Many Canadians are familiar with ranking lists of top Canadian employers. Since 2010, Canada's Top 100 Employers recognition program has held its competition for *Top Employers for Canadians Over 40* which celebrates employers who excel in eight evaluation criteria, namely whether:

1. They offer interesting programs designed to assist older workers;
2. They actively recruit new workers aged 40 years or older;
3. Their HR policies take into account the unique concerns of older workers, such as by recognizing work experience at previous employers in determining vacation entitlement;
4. They offer a pension plan with reasonable employer contributions;
5. They assist older employees with retirement and succession planning;
6. They create opportunities for retirees to stay socially connected to former co-workers through organized social activities and volunteering;
7. They extend health coverage and similar benefits to employees after retirement; and
8. They offer any programs, such as mentorship and phased-in retirement, to ease the emotional challenges of retirement and ensure older employees' skills are transferred to the next generation.

This and other types of public recognition programs should be leveraged to heighten the profile of employers who excel at supporting our older Canadians and working caregivers and to celebrate and spread knowledge and uptake of best practices that enable older workers and caregivers in our workplaces.[273] Engaging our federal, provincial and territorial governments in these activities will further advance our overall economic productivity and the ability of our employers to maintain a competitive advantage around the recruitment and retention of experienced and skilled older workers.

Evidence Informed Policy Brief # 12

Ensuring Caregivers are Not Unnecessarily Financially Penalized for Taking on Caregiving Roles

National Seniors Strategy Evidence Informed Policy Brief # 12

Ensuring Caregivers are Not Unnecessarily Financially Penalized for Taking on Caregiving Roles

Setting the Context:

Canada's unpaid caregivers play a vital role in supporting older Canadians and their desire and ability to age in their place of choice. While caregiving can be personally rewarding, it can also be stressful and expensive. As the number of older Canadians continue to increase, so too will the need for and numbers of unpaid caregivers and the demands placed on them. Statistics Canada recently estimated that **8 million Canadians over the age of 15 are serving as caregivers to family or friends;** with age-related health problems being one of the most significant drivers of caregiving needs.[274]

With the number of older Canadians requiring the support of unpaid caregivers projected to double over the next two decades[275], it is expected individuals of all ages, genders and income levels will inevitably face the abrupt need to serve in a caregiver role. This will also result in the majority of working Canadians over the age of 45 playing caregiving roles as well.

Despite the economic importance of their continued participation in the workforce, caregivers often end up earning less and foregoing advancements in their own careers than others without these additional responsibilities. According to the Canadian Caregiving Coalition, **15%** of working caregivers reduce their work hours, **40%** miss days of work, **26%** take a leave of absence, **10%** turn down job opportunities, and **6%** eventually quit their jobs. While the cost to working caregivers includes lost wages, and decreased retirement income, **19%** further report that their physical and emotional health suffers as well.

For employers, the productivity losses to them become enormous with the loss of 18 million work days per year, due to missed days and increased employee turnover. Indeed, **it is estimated that the cost to the Canadian economy from lost productivity is 1.3 billion per year.**

Caregivers also play a vital role in ensuring the overall sustainability of our health systems by providing alternatives to costly and publicly-funded facility-based care by often supplementing the care available through our limited publicly-funded home and community care systems. **It is currently estimated that nationally, annual savings across health, social and community care systems associated with care provided by unpaid caregivers is between $24-31 billion[276].**

What Are the Issues?

1. Access to Existing Financial and Other Supports for Caregivers Varies Significantly Across Canada

Currently only 14% of spousal caregivers, and 5% of caregivers to their parents report receiving any government financial assistance.[277] These low assistance rates have been attributed to a variety of issues including a general lack of awareness of available supports and how to easily access them; the requirements to qualify for financial assistance have also been criticized as being overly restrictive when some programs disqualify spousal partners, neighbours or friends serving as caregivers or those not living with the care recipient from accessing assistance.

Meanwhile, there is growing evidence demonstrating that financial support for caregivers can **reduce the probability that their dependents will be admitted to a nursing home by 56%.**[278] With a growing recognition of their overall importance, 93.8% of Canadians have indicated their support for a greater federal involvement in improving financial assistance available for caregivers who support ageing relatives and friends.[279]

Currently, both the federal (See Table 12) as well as provincial and territorial governments (See Table 13) in Canada provide a variety of financial and other supports for caregivers, although levels of support and eligibility criteria are not standardized across Canada.

For example, Quebec is the only province where tax credits for caregivers are refundable[280]; while every other Canadian jurisdiction and the federal government only offer non-refundable tax credits that are treated as income.[281] However, to claim a non-refundable credit, individuals must be employed and/or earning a sufficient income through others sources to claim this credit as a deduction.

While new commitments to caregivers were recently made in the 2015 federal budget, there has been criticism that they have failed to target those caregivers who are most in need of support. For example, the federal government announced the creation of a new tax-free Family Caregiver Relief Benefit for family caregivers of veterans. While this is a welcome development, veterans are among the best financially supported older adults in Canada.[282] It was also announced that the Compassionate Care Benefit would be extended from six weeks to six months. While this goes some way to recognizing the needs of caregivers, it remains a benefit accessible only to those with family members in "significant risk of death" and neglects acute episodic illnesses which often is a greater reason to require working caregiver to take temporary leaves from employment.

In addition to financial supports, respite services are understood to be very important to support the health and well-being of caregivers. Coverage for respite services across Canada, however, varies widely. Many provinces use an individual's income or income plus assets to assess eligibility of home-based respite services with a proportion of costs to be shared by families; namely: Newfoundland & Labrador, Nova Scotia, Prince Edward Island, New Brunswick, Saskatchewan, Alberta, and British Columbia. Provinces and territories where no direct costs are incurred by the user for home-based respite care include: Ontario, Manitoba, Yukon, Northwest Territories, Nunavut, as well as First Nations and Inuit Health Branch programs. [283]

Finally, some provinces have additionally recognized caregivers through the creation of specific legislation and granting programs, such as Manitoba and Nova Scotia respectively. Manitoba's legislation is particularly noteworthy as it provides the most inclusive definition of a caregiver, specifically recognizing the important role that friends and neighbours often play in caring for others.

Table 12. Federally Available Financial Supports for Caregivers and their Eligibility Criteria

Credit	Criteria
Family Caregiver Tax Credit [284]	*Eligible Claim:* $2,058 (claimed in addition to Caregiver Amount below) Care recipient must be a dependent with impairment in physical or mental function. ***Non-refundable**
Caregiver Amount[285] (line 315)	*Maximum Eligible Claim:* $4,530 (or $6,588 if eligible for Family Caregiver Tax credit above). The caregiver must dwell with dependent who must be 18 years or older and have a net income of under $20,002. If the dependent is a spouse's or common-law partner's parent or grandparent, they must be born prior to 1949. ***Non-refundable**
Compassionate Care Benefit[286] (Employment Insurance Benefit)	*Eligible Claim:* Maximum of 6 months of benefits payable to eligible individuals. Payable to those temporarily away from work to care for or support a family member who is gravely ill and who is at significant risk of death within 26 weeks. Must be able to demonstrate that normal weekly earnings have decreased by more than 40% and that the claimant has accumulated 600 hrs of work in the last 52 weeks (or since last claim). (NB: This benefit applies only to support for family members, the definition of which varies by province, and does not usually cover more episodic health care episodes where the family member could benefit from the presence of a family caregiver. Additionally, job protection regulations during leave are provincially regulated.)
Medical Expense Tax Credit[287] (line 330)	*Eligible Claim:* expenses that exceed the lesser of either 3% or taxpayer's net income OR $2,152 Applicable to medical expenses for individuals, spouses or common-law partners, and dependent children born 1997 or later. (NB – Does not include dependent parents) ***Non-refundable**

Table 13. Provincially Available Supports for Caregivers and their Eligibility Criteria[288]:

Province	Compassionate Care Leave (# of Weeks of Protected Leave)	Funded Respite Services Available	Specific Grant for Family Caregivers	Caregiver Specific Legislation	Caregiver Tax Credit*
BC	8	Y			$4,318 at net income threshold of $14,615
AB	8	Y			$10,296 at net income threshold of $16,371
SK	12	Y			$9,060 at net income threshold of $15,473
MB	8	Y		Bill 42, The Caregiver Recognition Act (2011)	$3,605 at net income threshold of $12,312
ON	8	Y			$4,557 at net income threshold of $15,593
QC	12	Y			$775-1,131 no net income threshold defined**
NB	8	Y			$4,473 at a net income threshold of $15,277
NS	8	Y	$400.00/ Month		$4,898 at a net income threshold of $13,677
PE	8	Y			$2,446 at a net income threshold of $11,953
NL	8	Y			$2,724 at a net income threshold of $13,313
YK[289]	8	Y			$4,530 at a net income threshold of $ 20,002[290]
NU	8	Y			$4,530 at a net income threshold of $ 20,002[291]
NWT[292]	8	Y			$4,530 at a net income threshold of $ 20,002[293]

* Indicates Net Income of Dependent not Caregiver

** Indicates Credit is Refundable

2. Canadian Women in Caregiving Roles are Particularly Financially Vulnerable

Certain subsets of caregivers are particularly financially vulnerable within our society. While men increasingly take on caregiving duties, women are still more likely to take on caregiving duties than men.[294] Women are also more likely to dedicate more time to caregiving duties and are more likely than their male counterparts to spend 20 or more hours per week on caregiving tasks such as personal care (e.g. bathing and dressing).[295] We now know that the subset of unpaid caregivers that end up facing the greatest level of financial hardship are older women.

One study of Canadian caregivers found that **73% where women**, while **74.9%** of them reported a personal income of **$39,999 or less** annually.[296] Lower incomes, compounded with more missed work and career advancement opportunities or premature retirements, have far reaching effects for female caregivers.

For example, Canada Pension Plan (CPP) benefits are derived from workforce participation-related contributions, making inconsistent workforce participation or early retirement detrimental to accruing future long-term pension benefits through this program. Furthermore, while a current provision exists within the CPP program to alleviate the financial penalty related to time spent out of the formal labour force caring for a young child, a similar provision for unpaid caregiving for others does not exist[297]; although, other countries do recognize the importance of this activity in their programs.

For example, in 2009 the Swedish parliament passed a law stating, "municipalities are obligated to offer support to persons caring for people with chronic illness, elderly people, or people with functional disabilities".[298] What's more, the definition of caregiver in the Swedish statutory context includes family members, relatives, neighbors, or friends that, "provide support to someone regardless of whether they live together".[299] We know that caregivers report the financial burden of caregiving as one of their greatest sources of stress, and finding ways to alleviate this issue more equitably should be considered a priority.

What's more, the definition of caregiver in the Swedish statutory context includes family members, relatives, neighbors, or friends that, "provide support to someone regardless of whether they live together".

We know that caregivers report the financial burden of caregiving as one of their greatest sources of stress, and finding ways to alleviate this issue more equitably should be considered a priority.

Evidence Based Policy Options to Consider

1. Improving Access to Information Around Available Financial Support for Caregivers

The low reported numbers of caregivers receiving any government financial assistance[300] has been partially attributed to a lack of awareness of available financial supports for Canadian caregivers. Therefore, ensuring that all Canadians can easily understand the benefits they are eligible for as caregivers, would especially benefit those who are particularly financially vulnerable within our society.

Although the federal government's www.seniors.gc.ca website serves an excellent starting point to access information for caregivers; many of its links redirect users to federal and provincial tax sites that use confusing and less accessible language to explain the eligibility criteria to access financial assistance. Therefore, enabling awareness of and access to user-friendly information and tools about available financial assistance for caregivers should be prioritized and has already been designated by the Canadian Caregiver Coalition[301] to be a key strategic priority to better address this issue.

2. Broadening the Definition of Caregivers and Family Members Eligible for Financial Assistance

Currently, the majority of the available financial assistance and various work leave allowances for caregivers are allotted to 'family' caregivers. For example, job-protected and compassionate leave only applies to family members of individuals.

Additionally, the definition of a family member in the context of caregivers and care recipient varies by province and by benefit or work leave allowance.

Specifically, inclusion of extended family members (aunts, uncles, cousins, spousal parents or grandparents) or other dependents often require separate or alternate applications for benefits, while the recognition of friends and neighbours who are increasingly taking on caregiving roles is seldom acknowledged either.

Federal leadership around revising and standardizing the definitions of 'caregivers' – be they family, friends or neighbours – and 'dependents' be they relatives or not, would support and recognize the increasingly changing nature of caregiver and care recipient relationships in Canada. Amendments to existing policies, that could also support the streamlining of existing assistance application processes, would likely encourage more individuals to take on and feel supported in caregiving roles regardless of a direct family relationship to a care recipient.

3. Removing Financial Assistance Barriers for Low Income Caregivers

Provincially, assistance for caregivers vary significantly, while we know that there are particular populations of low-income caregivers, often older women, who experience disproportionate financial hardship due to their more long-standing caregiving duties.

Most commonly, benefits for caregivers are means-tested based on the annual income of care recipients or 'dependents' rather than the financial means of caregivers themselves, while some tax-credits are 'non-refundable' meaning that if a caregiver is not employed or earning a sufficient income to qualify for these credits, then their lack of ability to access even these basic levels of financial assistance puts them at greater risk of having to give up their caregiving role.

Understanding the outcomes of more targeted methods developed to support caregivers in: Manitoba - with its broader definition of caregivers; Nova Scotia - with its targeted caregiver benefit for low income caregivers: and Quebec - with its refundable caregivers tax credit, may better inform the best Canadian strategies to ensure those most financially vulnerable in caregiving roles are adequately supported given the significant annual savings they generate for our publicly-funded health, social and community care systems.

ABOUT THE AUTHORS:

Our research team includes a small group of clinical, policy and research leads – working with the objective of providing evidence-informed strategic thinking to promote, debate and explore policy options that can support the development of a National Seniors Strategy.

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The following paragraphs provide more details on the members of our research team.

Dr. Samir K. Sinha MD, DPhil, FRCPC

Dr. Samir Sinha is a passionate and respected advocate for the needs of older adults. Dr. Sinha currently serves as the Peter and Shelagh Godsoe Chair in Geriatrics and Director of Geriatrics of the Sinai Health System and the University Health Network Hospitals in Toronto. In 2012 he was appointed by the Government of Ontario government to serve as the expert lead of the Ontario's Seniors Strategy. He is also an Assistant Professor of Medicine, Family and Community Medicine and the Institute of Health Policy, Management and Evaluation at the University of Toronto and the Johns Hopkins University School of Medicine. Recently, Dr. Sinha became the founding Co-Chair of the Advisory Board for Canada's new National Institute on Ageing at Ryerson University.

A Rhodes Scholar, Dr. Sinha's breadth of international training and expertise in health policy and the delivery of services related to the care of the elderly have made him a highly regarded expert in the care of older adults and around the implementation and administration of unique, integrated and innovative models of geriatric care that reduce disease burden, improve access and capacity and ultimately promote health. In 2014, Maclean's proclaimed him to be one of Canada's 50 most influential people and its most compelling voice for the elderly. Dr. Sinha is the co-principal applicant for the CIHR funding opportunity which supported this work.

Bailey Griffin, MSc, BHSc

Based at the Institute for Health Systems Solutions and Virtual Care (WIHV) at Women's College Hospital, Bailey oversees a number of key long-term initiatives, including acting as the Network Manager for the Ontario-wide Better Access and Care for Complex Needs (BeACCoN) Network, Ontario's contribution to a pioneering new CIHR SPOR initiative connecting research and evaluation to policy and practice to improve outcomes, quality and efficiency of care for patients with the most complex needs. Bailey acted as the overall research lead for the National Senior Strategy.

Thom Ringer, Hon BA, MPhil JD, MD(C)

Thom Ringer is a medical student and award winning medical researcher in geriatric medicine at McMaster University. In 2015 he received McMaster's 2015 Medical Student Research Award and the Canadian Geriatric Society's Willard & Phoebe Thompson Award. Previously, Thom served as a Senior Consultant in the strategy practice of a global management consulting firm, with a focus on health care and public sector engagements across Canada. He has also held managerial roles in the Ontario government, advising its senior leadership on a range of strategic initiatives. Thom has a law degree from Yale University, and a Master's from the University of Oxford, where he was a Rhodes Scholar. Thom acted as the research lead and author for the Informed Health Decision-Making & Advanced Care Planning Brief (Evidence Brief #7) within the National Senior Strategy.

Christina Reppas-Rindlisbacher, Hon BSc, MD(C)

Christina Reppas-Rindlisbacher is a medical student and researcher in geriatric medicine at the University of Toronto. Her work was recently published in the Journal of the American Geriatrics Society and received 1st place awards at the Canadian Association for Population Therapeutics conference and Geriatric Medicine University Research Day. She received the Leadership Education and Development (LEAD) scholarship in medicine to pursue graduate courses in business, clinical leadership, and health policy. Previously, she advised on a strategic plan for enhancing access to specialists at the University Health Network and helped develop policy recommendations for the Ontario Ministry of Health in support of family caregivers. She obtained a BSc in Life Sciences from Queen's University. Christina acted as the co-research lead for the Support for Caregivers Policy Briefs (Evidence Briefs #11 and #12) within the National Senior Strategy.

Emily Stewart, Hon BSc, MD(C)

Emily Stewart is a medical student at the University of Toronto who is passionate about evidence-based policy. She received the Leadership Education and Development (LEAD) scholarship in medicine to pursue graduate courses in business, clinical leadership, and health policy. Emily has worked in the Office of the Premier of Ontario with the senior policy advisor to develop policy recommendations for the Ministry of Health in support of unpaid family caregivers. Emily has been recognized for her research about policies on access to care for refugees by the Federation of Medical Women in Canada (FMWC), and her work was used in the Federal Court of Appeal. She obtained a BSc at Dalhousie University. Emily acted as the co-research lead for the Support for Caregivers Policy Briefs (Evidence Briefs #11 and #12) within the National Senior Strategy.

Ivy Wong MPA, M.P.A, BA

Based at the Institute for Health Systems Solutions and Virtual Care (WIHV) at Women's College Hospital, Ivy works on strategic initiatives to further policy and system improvement across health and other sectors. Ivy is also Network Director for the Better Access and Care for Complex Needs (BeACCON) Network.

Ivy recently returned to Canada after several years as a civil servant in the Department of Health in the United Kingdom, and most recently was the Head of Commissioning Policy and Incentives for the National Health Service (NHS) in London, England where she focused on issues of funding reform, integrated care and financial incentives. Before working in health policy, Ivy was an IT consultant, specializing in financial services, and also worked as an Account Director in digital marketing and advertising. Ivy provided policy advice on the National Senior Strategy.

Stephanie Callan, BA

Stephanie Callan is a Program Assistant with the Sinai Health System's Healthy Ageing and Geriatrics Program. Stephanie is responsible for developing communication, design, and web materials for the Healthy Ageing and Geriatrics Program. Stephanie received her Honours Bachelor of Arts from McMaster University, double majoring in Communications and Multimedia and completed her post-graduate studies in Corporate Communications at Sheridan College. She has a special interest in creating and supporting various multimedia projects, specifically for health and education initiatives. Stephanie provided all graphic design work for the National Senior Strategy and National Senior Strategy campaign as well as acting as this initiative's communications lead.

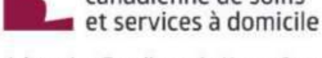
Dr. Geoffrey Anderson, MD, PhD

Dr. Geoffrey M. Anderson is a Professor in the Institute of Health Policy, Management and Evaluation (IHPME), Dalla Lana School of Public Health, University of Toronto, where he holds the Chair in Health Management Strategies.

Dr. Anderson has been involved in health services research for over 30 years. His research has been funded by provincial, national and international research agencies and he has published over 200 articles. He is actively involved in research on health and social care for older people and plays a leadership role in IHPME's graduate education programs. Dr. Anderson is the Nominated Principal Applicant for the CIHR funding opportunity which supported this work.

Alliance for a National Seniors Strategy

The Alliance for a National Seniors Strategy believes Canada urgently needs to establish a plan to meet the growing and evolving needs of our ageing population. The work of developing an evidence-informed National Seniors Strategy has become a collaborative opportunity to build upon the expert work of others. The main national organizations that offered advice and support and their eventual endorsement for this overall body of work are also acknowledged below. These organizations in particular broadly represent a growing group now being increasingly recognized across Canada as the Alliance for a National Seniors Strategy.



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DES PROCHES AIDANTS

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