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Advancing the inclusion of people with disabilities

With a special section on seniors

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Message from the Minister

Advancing the Inclusion of People with Disabilities 2005 is the Government of Canada's third report detailing its progress on disability issues. Prepared with the input of some 30 departments and agencies, as well as stakeholders, researchers and members of Aboriginal organizations, it presents an overview of developments in Government of Canada disability policy and a profile of expenditures on disability. This year's report also includes a special focus on seniors with disabilities. As the report shows, we are learning more about the relationship between aging and disability and the potential impact of this growing population on disability policy priorities.

Canada is at an exciting stage in its history. We have a strong and growing economy, and a quality of life that is recognized the world over. For people with disabilities, we must realize our vision to create a truly accessible Canada. A Canada where, thanks to adaptation, to technology, and to supports of various kinds, all can live full, realized, Canadian lives. Accessible in our streets and in our communities, accessible in our homes, workplaces and educational institutions, accessible at all the different stages of our lives; and, crucially, accessible in the minds of persons with disabilities and in those without disabilities.

I encourage you to share and discuss this report with others and to provide us with your feedback. An accessible Canada should happen and it can happen. We need to work together to create the environment of possibility that can make it happen.

Ken Dryden, P.C., M.P.
Minister of Social Development

CHAPTER 1
INTRODUCTION

Canadians are living longer. As we age, the chance of having a disability increases. Disability affects people of all ages. After age 65 about one in three of us have developed a disability, and that likelihood continues to increase as we grow older. What are the implications of aging with a disability?

Many Canadians have their first experience with disability through their family. Aging grandparents and extended family members often provide us with our first experience of mobility, sight, hearing, mental and emotional issues associated with disabilities. As many know and research demonstrates, most seniors with disabilities live fully, participating actively in the lives of their families and communities. Many seniors with disabilities have all the supports they need but some lack needed supports and thus face barriers to full participation and inclusion in society.

Advancing the Inclusion of Persons with Disabilities 2005 is the Government of Canada's third comprehensive report on disability in Canada. The 2005 report builds on the foundation established by the previous two reports. Through these reports, the Government is meeting its obligation to be accountable to Canadians for the results of its disability policy and programming.

This year's report is the first of a series that will focus on people with disabilities at different stages of their lives. This report highlights seniors and Aboriginal elders with disabilities, presenting some of the challenges they face and reviewing progress in the policies and programs aimed at fostering their inclusion in Canadian society. Future reports will feature children and youth and working-age adults.

THE ACCOUNTABILITY FRAMEWORK

Reporting back to Canadians on progress on disability issues began with a Government of Canada commitment to the House of Commons Subcommittee on the Status of Persons with Disabilities in 1999. The first report in 2002 presented a comprehensive accountability framework designed to help Canadians assess the Government's success in promoting the full inclusion of people with disabilities. The framework identified important aspects of inclusion, provided indicators for measuring progress and linked Government of Canada programs, policies and expenditures to them. Building on this framework, a second report was released in 2004. It included improvements based on suggestions from members of disability organizations, Aboriginal organizations, academic experts and disability researchers.

FIGURE 1.1 THE ACCOUNTABILITY FRAMEWORK

The accountability framework presented in *Advancing Inclusion* is built around six outcome areas: disability supports, health and well-being, income, skills development and learning, employment, and capacity of the disability community. These outcome areas (illustrated in Figure 1.1) represent the building blocks of full inclusion.

Skills development and learning: Adults and seniors with disabilities want to learn and develop skills whether for employment or for other reasons. Children and youth with disabilities, like all children, require opportunities to participate in formal education to gain the knowledge and skills needed later in life.

Employment: Having paid employment is often the key to economic independence and full participation in the community. However, issues such as lack of experience or appropriate skills, inaccessible transportation, employer and public attitudes and the lack of information on potential opportunities can all make finding steady employment difficult. Government programs aim to help reduce these obstacles so that people with disabilities may obtain and retain stable employment.

Disability Community Capacity: People with disabilities themselves, along with the organizations that serve or represent them, all help to advance inclusion. The government contributes by providing support and resources to help voluntary sector organizations effectively run disability programs, contribute to policy and program development, and stimulate the involvement of people with disabilities in civic and volunteer activities.

Disability supports: Individuals with disabilities may need goods and services such as special equipment, help from friends, family and agencies, respite care or modifications to homes, vehicles, workplaces and recreational facilities. Supports may also be provided to families and caregivers to help them carry out their responsibilities. Disability supports also include accessible environments and systems such as transportation, public buildings and accessible information. Disability supports are the essential foundation for people with disabilities to actively participate at home, in school, at work and in the community.

Health and well-being: Good health is another foundation of individual participation in society. Health is more than the absence of disease. The World Health Organization defines health as complete physical, mental, and social well-being. Environmental and social factors, individual behaviour, violence and injuries, as well as chronic and mental conditions all have an impact on the well-being of people with disabilities.

Income: Having enough money to meet personal and family needs including activity in the community is essential to the well-being and inclusion of people with disabilities. Many factors influence how much income people have, including the ability to be employed, the adequacy of income support, and the cost and availability of disability supports.

Each of these six areas represents an important aspect of inclusion and all are related. To present them more fully, a set of indicators of progress was identified and elaborated in the 2002 and 2004 reports. Analysis of these indicators has led to recognition of issues and monitoring of progress that can be reported to citizens.

■ IN THIS REPORT

Part 1 of this year's federal report will fill an important knowledge gap about seniors and disability. It first looks at some of our ideas and understanding about seniors, aging and disability. Subsequent chapters then cover inclusion issues following the structure of the accountability framework.[1]

Based on discussions with disability organizations, seniors organizations and

experts, this year's report emphasizes disability supports, health and well-being and income. Beyond the indicators presented in the selected outcome areas, there are also issues of particular importance to seniors with disabilities that are not part of the original indicator framework. Community participation, housing, medication use and quality of life are considered important topics not well-represented by the current indicator framework. *Supplemental indicators* have been added to this report to provide a more comprehensive portrayal of some of these topics while others are addressed by discussion in the text. Figure 1.2 provides more details on the portions of the accountability framework highlighted in this 2005 report.

Along with the discussion of indicators, each chapter also identifies important Government of Canada initiatives addressing the needs of seniors with disabilities. (Brief descriptions are provided in Appendix C). The section ends with a chapter addressing specific questions related to Aboriginal elders with disabilities.

Part 2 of *Advancing the Inclusion of People with Disabilities 2005* presents information on recent disability policy developments and progress towards developing a long-range disability agenda. A description of what the Government of Canada is doing to contribute to the development of knowledge on disability issues, as well as an updated federal disability expenditure analysis are also presented.

In Part 3, the report concludes with a brief review of developments associated with the Labour Market Agreements for Persons with Disabilities (LMAPD).

FIGURE 1.2 INDICATORS OF PROGRESS HIGHLIGHTED IN THE 2005 REPORT

Employment

- Employment rate

Disability Community Capacity

Supplemental indicator:

- Volunteering and community participation

Disability supports

- Aids and devices
- Help needed for everyday activities
- Home modifications
- Supports for family caregivers
- Transportation
- Information in multiple formats

Supplemental indicators:

- Housing
- Medication support

Health and well-being

- Health Status
- Impact of chronic conditions
- Impact of mental conditions
- Impact of injuries
- Impact of individual behaviour factors
- Impact of environmental factors

Supplemental indicator:

- Health-related quality of life

Income

- Household income
- Persons living in low-income households
- Major source of personal income
- Food security
- Net worth

IN SUMMARY

In summary, the 2005 report demonstrates the Government's accountability for its disability policy and programming in three ways:

a) Part 1 uses the outcomes and indicators developed in previous reports to show how the Government is addressing the needs of seniors with disabilities
b) Part 2 demonstrates how the Government is working to advance the overall disability policy agenda and outlines its disability-related expenditures
c) Part 3 fulfills the Government's commitment to report annually on achievements under the Labour Market Agreements for Persons with disabilities

CHAPTER 2
SENIORS, AGING AND DISABILITY

HIGHLIGHTS

- In many discussions of health and illness, disability is portrayed as a condition to be delayed or avoided as long as possible
- Older people who remain socially connected and engaged are more likely to remain happier and in better health
- Typically, medical and functional problems occur at 70-75 years of age; for people with disabilities these problems occur 20-25 years sooner
- By the time seniors are aged 75 or older, more than half experience at least one disability
- The double stigma of aging plus disability may cause seniors to reject disability as a label
- Seniors often see the use of aids and devices as a sign of increased frailty while the disability community sees them as tools for increased independence
- When seniors themselves are asked to describe successful aging it includes things like loving relationships, graceful acceptance of change, moderate living, having goals and maintaining a sense of humour

By 2026, it is projected that there will be over 3 million people with disabilities over 65 years of age—up from 1.6 million in 2001—almost double in 25 years

THE AGING of the Canadian population is a popular topic with policy experts, academics and the media. Disability is often portrayed as a condition to be avoided or as a future and growing burden on the country's health care system. At the same time, work on disability often focuses on the challenges of including children, youth and working-age adults in society and seldom looks specifically at seniors. In this environment, the implications of an aging population for disability policy have not been systematically explored, creating a gap in knowledge which this report begins to address. This chapter sets the stage for discussing seniors with disabilities, by examining several related questions:

- Who are seniors with disabilities and how will population aging change the composition of the population with disabilities?
- What is the relationship between aging and disability? Are there differences between those who acquire a disability early in life and those who first become disabled in their senior years?
- What pressures might be exerted on disability policy priorities by the increasing numbers of Canadian seniors with disabilities?

■ DEFINING THE SENIORS POPULATION

In Canada, people often think of seniors as those aged 65 and over. However, the notions of old age, older persons and seniors have changed: "seniors" have been defined as young as 50 (e.g. Canadian Association of Retired Persons), 55 ("freedom 55"), 60 (the United Nations definition of older persons), and 65 (eligibility for Old Age Security and Guaranteed Income Supplement).

Increasingly, we're recognizing that those beyond age 65 are not a homogenous group. Gerontologists speak about the young-old

(ages 65-74), the middle-old (75-84) and the oldest-old (85 and over), noting that there are major differences in functional status, needs and interests of these groups. For many health care planners, the focus is on the 85+ group, in recognition that older seniors make the greatest demand on the health care system and that they are the fastest growing segment of the population.

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"I do not know how to define old age. In years I would say over 65. In spirit it could be any age. I don't think I am 'old' although I am aged."[2] (Mary, 75)

"If all those things that you enjoy are behind you and you're not enjoying the latter years of life because you're lonely, then I think you're old. My impression of getting old is physical frailty, of mental slowdown, weighting those two factors against the continual factor of experience".[3] (Mr. King, 70-80)

Defining seniors based on chronological age alone does not provide an accurate picture of this very diverse population. Using an age threshold may be useful for some purposes but an alternative is to focus on the process of aging itself—recognizing that individuals "age" at different rates. This report uses age 65 as a threshold to build on the extensive body of research and policy that has been constructed while also examining differences among "young" and "old" seniors.

■ DEFINING SENIORS WITH DISABILITIES

The historical emphasis on a medical view of disability is increasingly being complemented by a social perspective that highlights disabling obstacles in the physical, social and cultural environments. Both the medical and social models of disability are finding their way into the thinking of administrators, service delivery professionals and policy makers. More recently, the role of culture and establishment of "common sense" expectations of what is "normal" have been a focus of disability studies.

"Traditionally, disabilities were viewed through a medical lens and defined as a 'health problem' or 'abnormality' that must be cured. Most people are familiar only with this outmoded "medical model" of disability."
— ARCH: A Legal Resource Centre for Persons with Disabilities[4]

Concepts of and attitudes towards disability play a foundational role in shaping popular and policy roles in disablement—whether disability is seen primarily as a medical issue, a consequence of social obstacles, or a cultural assumption matters a great deal.

In many discussions of health and illness, disability is portrayed as a condition to be delayed or avoided as long as possible.

Much of the literature on seniors and aging has focussed on issues surrounding illness and health care. Disability is often viewed as a potential negative outcome of aging—something that people 'age into'. In addition, frailty, illness and disease are associated with aging; certain illnesses/diseases are linked with old age such as Alzheimer disease, Parkinson disease, arthritis, etc. In many discussions of health and illness, disability is portrayed as a condition to be delayed or avoided as long as possible—a sign of decline and a precursor of death. With this orientation, it is not surprising to find a great reluctance on the part of seniors to acknowledge that they may be experiencing a disability.

Disability scholars and organizations, however, have moved from focusing on health/illness to a focus on 'activity limitation' and to viewing disability as a result of social and environmental factors and a matter of human rights.

Within the disability community, in Canada and

around the world, there has been a rejection of the 'medical model' of disability and a general acceptance of the 'social model' to guide thinking about disability issues. For example, when a child or a young adult experiences a disability it is a situation that must be addressed to get on with life. Frequently, the obstacles are found in the environment itself. In this case, the response to disability is to address the obstacles through changes in attitudes, physical spaces and systems. This social model of disability has found its way into Canadian legislation (e.g. the *Employment Equity Act*), federal, provincial and territorial disability policy (e.g. *In Unison*) and the Supreme Court of Canada, which has adopted a "social model" of disability in key disability human rights decisions.[7]

Beyond the social model, some have proposed that disability may ideally be experienced as another perspective from which to view the world—a reality of normal human variation—having little to do with health or well-being *per se*. Disability culture and rights activists may see the experience of disability as something to be celebrated. One of the challenges to bringing the worlds of disability and seniors/aging together will be to work out the implications of integrating different ways of thinking about disability into the thinking that guides the seniors' movement and government policy for aging/seniors.

AGING INTO DISABILITY

Tom[5] was a very self-sufficient widower until age-related macular degeneration struck at age 84. Within weeks he lost his sight and suddenly found himself virtually alone, with no immediate family to support him. With support from the Victorian Order of Nurses, Visiting Homemakers and Meals on Wheels, he continued to live in his apartment. He was also referred to the CNIB and, after a period of emotional adjustment and some training on how to manage with his vision impairment, he became quite active in a seniors group. He went on his first trip by air at the age of 86 to Florida. At 89 he went to Hawaii. When he died months after his 90th birthday, his granddaughter found a form he had completed to sign up for a trip to China.[6]

ESTIMATING THE CURRENT AND FUTURE POPULATION OF SENIORS WITH DISABILITIES

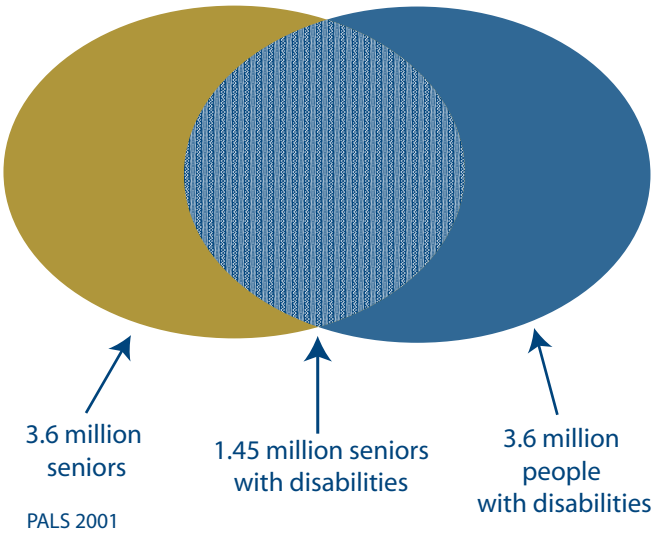
Seniors represent a significant portion of the population with disabilities. Their presence in the population with disabilities will continue to grow as the population ages. In fact, by 2026, the number of seniors with disabilities could rise to over 3 million, almost double the 1.62 million in 2001.

The majority of seniors with disabilities live in the community, while a much smaller portion live in institutional settings. The Participation and Activity Limitation Survey (PALS) is the main source of information about seniors with disabilities living in the community. In PALS, people are asked whether a physical, mental or health condition reduces the amount or kind of activities they can complete at home, work, school, leisure, transportation or in other areas. Disabilities are presented as "activity limitations" and not just health conditions. This approach draws the attention of respondents to their environment and how well they can function within it.[8]

According to PALS, there were 3,587,000 Canadian seniors and 3,601,000 people with disabilities in 2001. Seniors with disabilities numbered 1,452,000 representing approximately 40% of both seniors and people with disabilities.[9]

The most common types of disabilities among seniors living in the community are mobility (43% of those age 75 and over; 25% for those 65-74 years of age in 2001) and agility limitations (40% aged 75 and over; 23% for those 65-74 years of age) which are frequently accompanied by pain-related limitations (31% for those age 75 and over; 22% for those 65-74 years of age). Hearing

2.1 Canadian Seniors with disabilities living in the community 2001



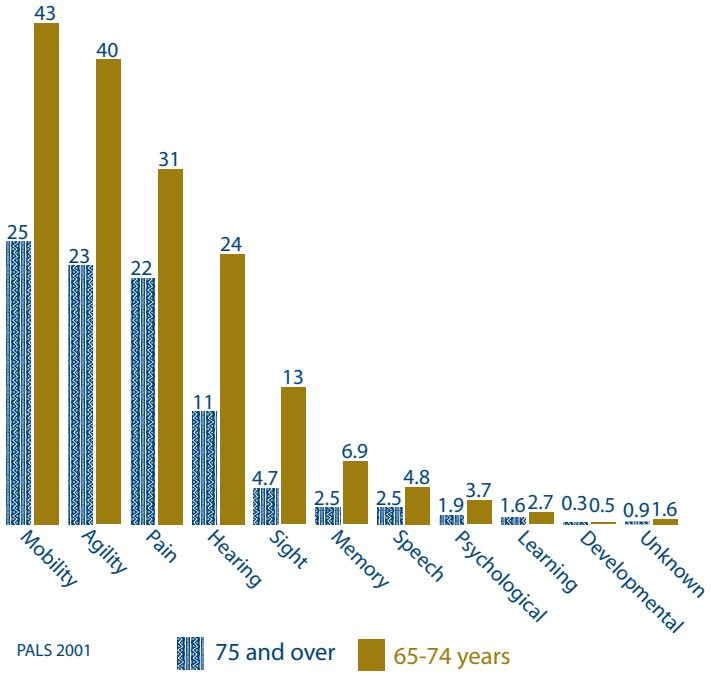
disabilities, visual impairment and memory loss also affect significant numbers of seniors. These disability frequencies are consistent with health statistics concerning major causes of late-onset disabilities which are injuries, non-communicable chronic conditions and degenerative conditions including dementia and sensory loss. Figure 2.2 illustrates the rates of major disabilities found among seniors in the community. The percentage figures total to more than 100 because well over 80% of all seniors with disabilities have multiple disabilities as defined by PALS.

A NOTE ABOUT VETERANS

In March 2005, the total Canadian War Service Veteran population was estimated to be 258,490:

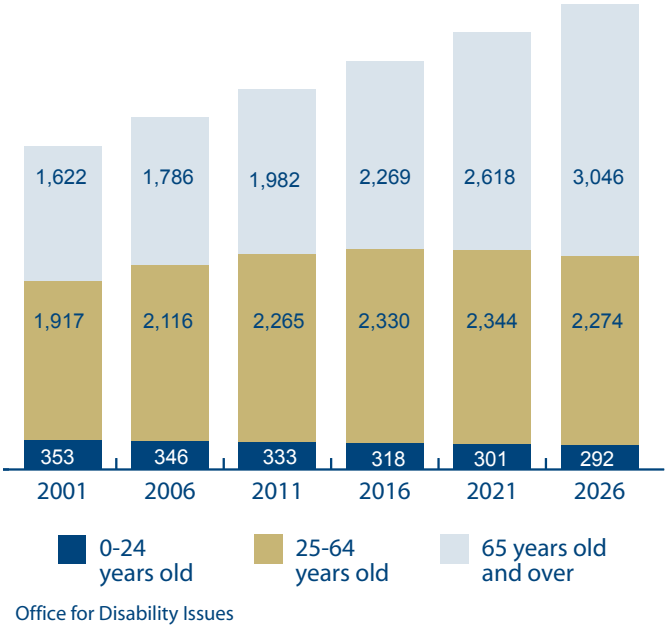
- Approximately 6% of all seniors are War Service Veterans
- Almost 13% of Canadian male seniors are War Service Veterans
- War Service Veterans are older than the senior population in Canada (average age is 82)
- War Service Veterans account for over 40% of males 80 years and older
- War Service Veterans are very concentrated around the ages of 75 to 84, as over 71% of Veterans are in this age group compared to only 35% of seniors in Canada.
- Approximately 36% (92,200) of War Service Veterans are Veterans Affairs Canada clients and 24% (62,139) of them were in receipt of a Veterans disability pension in 2005.

2.2 Types of disabilities among Canadian seniors with disabilities (%)



How will population aging affect the size and age composition of the population with disabilities in the future? Figure 2.3 illustrates one possible answer to this question, showing that the overall size of the population with disabilities may increase from 3.9 million in 2001 to 5.6 million in 2026. This corresponds to an increase in the percentage of people with disability from 12.6% to 16.4%. This projection is based on the general aging of the population starting from a Statistics Canada low-growth projection of the total Canadian population.[10] Other population growth assumptions or more sophisticated projection methods yield somewhat different results but the overall patterns remain very similar. (See Appendix B for more details.)

2.3 Population with disabilities by age, Canada 2001-2026
Low growth population scenario



Office for Disability Issues

The age composition of the population with disabilities will change as well. In 2026 approximately 54% of people with disabilities will be seniors versus 42% in 2001. Those 25-64 years of age will be about 40.5% of the population with disabilities in 2026 versus 49.2% in 2001. The percentage of those with disabilities represented by children and youth 0-24 years of age will be reduced from 9.1% to 5.2%.

The projection shows that by 2021 seniors with disabilities will outnumber those with disabilities 25-64 years of age and by 2026 the majority of people with disabilities will be 65 years of age or over—some 3.05 million. While it will remain critically important to continue improving support for younger people with disabilities, disability policy will also have to take into account this shift in the composition of the population.

■ WHAT IS THE RELATIONSHIP BETWEEN AGING AND DISABILITY?

Aging is a multi-dimensional process. The Canadian Initiative on Frailty and Aging describes one model of aging as a "dynamic complex process" and an "interaction of biological, psychological, cognitive and social factors".[11] In a very similar model of aging, The Victorian Accommodation & Ageing Committee (Australia) considers three dimensions of aging: "physiological changes, psychological changes and/or social expectations".[12]

Older people who remain socially connected and engaged are more likely to remain happier and in better health.

Physiological changes occur at different rates for different people. However, changes such as reduced stamina, less efficient circulation, vision and hearing impairments, increasingly frail bones and increased risk of chronic disease and medical problems occur with increasing frequency as we age. Psychological changes can include changes to motivation, learning and personality resulting from personal loss, dementia, social isolation or other causes. Social expectations, rooted in culture, influence decisions around family, work, community and leisure as individuals age. However, older people who remain socially connected and engaged are more likely to remain happier and in better health. There is tremendous variation among seniors, and many individuals maintain capabilities beyond those of much younger people even to the very end of life.

VARIATIONS IN AGING

Louise is 95 years old and, until 2003, lived in the same apartment she and her late husband had shared for some 60 years. After Bob died, Louise carried on. She's never had a television and never driven a car. She walks everywhere and, even now, in December 2005 goes out weekly to get basic groceries. Her assisted living residence can adapt to her changing needs as she gets older. But, for now, she's out there every day walking and just getting on with a lifetime of being active.[13]

Building on the multi-dimensional nature of aging, the World Health Organization (WHO) has urged countries to focus on "active aging" to address the challenges of an aging population. "Active ageing is the process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age."[14] The belief is that for aging to be a positive experience, increasing years must be associated with continued opportunities for health, security, and participation in social, economic, cultural, spiritual and civic affairs. The WHO active aging framework recognizes that factors affecting successful aging are important through all stages of life.

"….[Seniors] still have an interest in life [and want] to be active. Seniors don't just sit in the background and observe, they participate and they are encouraged to participate".[15]

Using this multi-dimensional understanding of aging, there are at least three ways in which aging and disability are related:

- The majority of seniors with disabilities "age into disability", that is, they first acquire a disability after the age of 65.
- People with disabilities may experience some aging processes at younger ages;
- Despite earlier "aging" for some people with disabilities, life expectancies are increasing.

Analysis of PALS 2001 provides estimates of the numbers of seniors who are aging with disabilities and of those aging into disability. [16] Table 2.1 shows that approximately 609,000 seniors, including 198,000 who are over 75 years of age, acquired their disability prior to their 65th birthday and are aging with a disability. Of those disabled before 65 years of age, 43.8% acquired a disability prior to 55 years of age, many of them at significantly younger ages (analysis not shown in table). In contrast, about 726,000 seniors with disabilities, including 72.8% of those 75 years of age and over acquired their disability sometime after the age of 65.

Typically, medical and functional problems occur at 70-75 years of age; for people with disabilities these problems occur 20-25 years sooner

Research is finding that the physiological and psychological changes of aging occur earlier for people with lifelong or early-onset disabilities and those with mid- to later-life onset of disability, such as stroke. Two populations likely to experience early onset of physiological aging are "those aging with developmental or early-life onset of disability, including cerebral palsy, mental retardation [sic], polio and multiple dystrophy" and "those aging with young adult onset of disability such as spinal cord injury, traumatic brain injury and rheumatoid arthritis".[17]

TABLE 2.1 Aging with and aging into disability (PALS 2001)

	Younger seniors (65-74)	Older seniors (75 and over)	TOTAL
Aging with disability (disabled prior to age 65)	411,200 (67.9%)	198,290 (27.2%)	609,490 (45.6%)
Aging into disability (disabled after age 65)	194,720 (32.1%)	531,340 (72.8%)	726,060 (54.4%)
Total	605,920 (100%)	729,630 (100%)	

Typically, aging is not accompanied by a high rate of medical and functional problems until after 70-75 years of age. However, people with disabilities show these higher rates 20-25 years sooner. People with disabilities also have three to four times the number of secondary health problems compared to their peers without disabilities.[18]

Until recently, earlier aging and other factors often led to death well before the age of 65 for people aging with a disability. However, in Canada and in many parts of the world people with long-term disabilities are living longer lives due to better medical care, nutrition, supports and societal changes. In the past, the average life span of a person with Down syndrome was 40 years but this has now increased to 55 years.[19] People with spinal cord injuries and various types of chronic conditions leading to disabilities are increasingly living past their 65th birthday. PALS estimates that approximately 11,000 individuals with developmental disabilities are 65 years of age or over.

By the time seniors are aged 75 or older, more than half experience at least one disability

Increasing rates of disability at older ages highlight the reality of seniors acquiring a disability for the first time. Whether caused by age-related physiological changes, falls, or other causes, by the time seniors are aged 75 or older, more than half experience at least one disability. For many, the first and perhaps most difficult adaptation to continue "aging successfully" may be to acknowledge their condition. Negative social attitudes towards disabilities cause many people who are growing older to fear the prospect of the onset of disability and how this might impact their lives. These individuals may not feel comfortable with using disability-related services, advocacy groups, etc. They may not want to identify themselves with other seniors with disabilities, feeling that it symbolizes loss of independence and dignity and recognition of mortality.

The double stigma of aging plus disability may cause seniors to reject disability as a label

Seniors may not accept the label of disability, even when formal structures and systems tell them they have a disability. Although such labels are sometimes necessary to access supports, negative attitudes towards both aging and disability (double stigma) can create reluctance to accept them. In some cases, seniors may refuse "disability" as a label, while acknowledging the impairment itself (recognizing for example, a loss of hearing but not accepting the "label" of disability: "I'm just getting old!").[20] Cultural differences, religion, language, family role, age, gender, and social environment may all play a role in whether and how a person will self-identify as a senior with disabilities.

■ DIRECTIONS FOR DISABILITY POLICY IN LIGHT OF POPULATION AGING

Over the past several decades, disability policy has broadened from a focus on rehabilitation and prevention to encompass rights-based support for full inclusion of people with disabilities. Governments have been putting in place the necessary legislation, regulations, programs and policies to facilitate the full participation of Canadians with disabilities in all facets of society—effectively moving disability policy beyond the realm of health policy and into domains of human rights, economic and social policy. While such efforts have been criticized frequently for not going far enough or for providing inadequate resources, the basic direction has met with the support of Canadians with disabilities and their families.

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"When it comes time for decisions concerning my health, my money, and how and where I want to live and die, I am fully in charge of myself and my family…. Just because a man is getting old and a bit slow does not mean that others can force their way into his life and tell him what's good for him. No Siree…never."[21] (Male, 72)

Canadians with disabilities and governments have identified a wide range of issues to be addressed by disability policy in order to support their full participation and inclusion. Many are

common to all or most people with disabilities, while some are more important to particular groups. Common priorities include:

- access to necessary assistance with daily activities, including specialized care;
- technology supports and other types of aids;
- accessible transportation;
- affordable, appropriate and accessible housing;
- opportunities for healthy living activities, leisure and recreation; and,
- safety, security and freedom from abuse or discrimination.

People with disabilities of different ages share these priorities but they also experience needs associated with their stage in the life cycle. Table 2.2 provides some examples of issues having a greater impact on Canadians with disabilities at three different stages of life:

- **Children and youth**: early interventions and support to ensure a good start in life are essential. Other key concerns include the impact on families, access to education, and transitions from the world of school to work or life in the community.
- **Adults 25-64 years of age**: obtaining a steady and adequate income through employment or government income assistance programs is a critical priority.
- **Adults age 65 and over:** Seniors with disabilities may face declining health and often depend on informal caregivers to live successfully at home and in the community.

Policy priorities may be identified based on how well existing systems are dealing with the issues. However, another key factor influencing the range of approaches to dealing with these issues and to planning is the number of people who will experience them in the future. Table 2.2 illustrates graphically that on the basis of population counts, the issues faced by Canadian seniors with disabilities will be growing in significance over the next two decades. The number of seniors with disabilities is expected to nearly double between 2001 and 2026. In the same period, the number of children

TABLE 2.2 Disability policy needs of greater concern by age groups

Age group	2001		2026		Age-specific priorities
	Disabled (000s)	% of total Pop.	Disabled (000s)	% of total Pop.	
0-24	353.3	1.1	291.1	0.9	Early detection and intervention Impact on families Access to education Transition to employment and community
25-64	1,916.6	6.2	2,273.7	6.6	Low incomes Access to employment including return to work for those with new disability(ies)
65 +	1,621.6	5.2	3,046.0	8.9	Health problems due to aging Supports to remain at home Impact on informal caregivers Low income among those living alone
TOTAL	**3,891.6**	**12.6**	**5,611.8**	**16.4**	

and youth with disabilities will decline and the number of adults aged 25-64 will remain stable. However, the dramatic increase in the overall population with disabilities and the disability rate between 2001 and 2026 highlights the need to continue making progress on issues faced by all Canadians with disabilities.

A challenge for disability policy over the coming years will be to preserve and enhance supports needed by younger people with disabilities while anticipating the rapid growth in the numbers of older people with disabilities. A parallel challenge is to recognize that the conditions and issues facing today's working-age population will impact the lives of tomorrow's seniors with disabilities.

■ DIRECTIONS FOR SENIORS POLICY

As the prospect of population aging has taken on increasing urgency, government policy frameworks focused on aging have also broadened. Seniors have been invited to participate in the policy development process. The National Advisory Council on Aging (NACA) was created to assist and advise the Minister of Health on all matters related to the aging of the Canadian population and quality of life of seniors.[22] Federal, provincial and territorial ministers responsible for seniors adopted the *National Framework on Aging* in 1998 highlighting the principles of dignity, independence, participation, fairness and security to guide policies affecting the well-being of seniors.[23]

When seniors are asked to describe "successful aging" it includes things like loving relationships, graceful acceptance of change, moderate living, having goals and a sense of humour

Seniors have expressed concerns about "successful aging" as a goal. NACA cautions that concepts like successful aging and active aging can make it seem that those who have aged most successfully are those who have aged the least. When seniors themselves are asked to describe successful aging it includes things like loving relationships, graceful acceptance of change, moderate living, having goals and a sense of humour.[24] These concerns seem to echo those of people with disabilities who consistently maintain that many valuable contributions of people with disabilities are not recognized when disability policy over-emphasizes activities like employment and education. This concern has been voiced with regard to working-age people with disabilities, but it seems even more applicable when considering seniors with disabilities. There are other examples of a conceptual overlap between disability policy and seniors policy. A recent framework to support active aging developed jointly by Canada and Mexico for the Pan-American Health Organization sets out principles for a comprehensive system of support that bear a striking resemblance to those found in disability policy work.[25] The principles stated include: safety, security and social support; fairness and equity; dignity; independence; and participation. There are clear similarities with independent living values developed by the disability movement such as autonomy and control and peer support. The discussion in the document encompasses the education, housing, transportation, labour, social and legal and health sectors and their role in providing a comprehensive system of support for seniors with and without disabilities.

Universal design principles are another example of an approach to meeting the converging needs of seniors and people with disabilities. Universal design means designing products, services and environments to make them more usable by all people regardless of age or disability. Designs advocated by universal design practitioners include power sliding doors at main entrances of commercial and public buildings and captioning on television. The Canadian Standards Association recently completed and published its latest barrier-free standard (CSA-B651 2004), which refers both to seniors and people with disabilities as well as other citizens as beneficiaries.

REMAINING AT HOME

Jessie turned 95 in October 2005. She still lives in the same apartment she's had in Kingston for almost 40 years since her husband died. A few years ago, Jessie developed a severe infection and lost her right leg below the knee. With a prosthetic leg, a walker and, at times, a wheelchair, Jessie is able to remain in her home. She also receives daily help from a home support worker and supplemental support from a young lady with Crohn's disease who comes by daily to visit and keep her company.[26]

Seniors often see the use of aids and devices as a sign of increased frailty while the disability community sees them as tools for increased independence

Efforts in seniors and disability policy to create integrated solutions to common issues face the reluctance of some seniors to identify themselves as being disabled and of those with disabilities to identify as being seniors. Seniors often see a limitation as something other than a disability. Younger people with disabilities naturally want to identify with their age-peers while seniors who have aged with a disability may identify with the groups and support systems with which they were affiliated in earlier years rather than with other seniors.

These differences in attitude come down to how people view aids and devices, for example: seniors often see their use as a sign of increased frailty, while the disability community sees them as important tools for increased independence. As well, situations can differ significantly between people who have lived with a long-term disability and people who are experiencing disability with aging. Seniors who, for example, experience disability starting at age 70 may have very similar incomes to other seniors without disabilities but higher than seniors who acquired their disability at age 40.

Creating a National Seniors Agenda: Report of the Prime Minister's Task Force on Active Living and Dignity for Seniors was released in May, 2004. This report delivered a series of 17 recommendations to the Prime Minister on steps to address seniors issues.[27] The Government of Canada has started development of a National Action Plan for Seniors. This action plan will involve examining a range of strategic issues affecting the situation of the seniors population of today and tomorrow. The process will provide an important opportunity to advance the inclusion of seniors with disabilities and, potentially, people with disabilities more generally.

CHAPTER 3
COMMUNITY PARTICIPATION AND EMPLOYMENT

HIGHLIGHTS

- On average, older seniors, including seniors with disabilities, spend eight hours a day in leisure activities
- 21% of seniors with disabilities are active volunteers in their communities, compared to 18% of all seniors who do volunteer work
- In 2003, 11% of seniors 65 to 69 years of age with disabilities were employed all year in comparison to 16% of their age-peers without disabilities

For seniors with disabilities, the ability to participate actively in their community and their families is essential. For some, continued participation in the labour market also fulfills important needs. This chapter examines the participation of seniors with disabilities in the community and in the workplace. Disability supports required for that participation are addressed in detail in Chapter 4.

As described in Chapter 2, "active aging" is an approach whose goal is to maintain and enhance seniors' ability to continue participating actively. With appropriate and comprehensive support systems in place assuring the safety, security, social support, justice, dignity, and independence of aging people with disabilities, active living conditions can be met. These supports can take the form of caregivers and the network of family members and friends, community services, as well as adequate public policies and programs.[28]

With these supports, seniors with disabilities can engage and contribute in their own way. Many participate in religious activities, lifelong learning activities and leisure pursuits, get involved in politics, or attend cultural events to name a few. Maintaining choice and independence in self-care and leisure are also essential elements of active participation.

INDICATORS

BOX 3.1 INDICATORS OF COMMUNITY PARTICIPATION AND EMPLOYMENT

COMMUNITY CAPACITY

Supplemental Indicator

- Volunteering and community participation

EMPLOYMENT

- Employment rate

On average, older seniors, including seniors with disabilities, spend eight hours a day in leisure activities

According to Statistics Canada, on an average day, adults 70 years of age and older spend nearly eight hours in leisure activities such as socializing, hobbies, reading, exercise or watching television. Another four hours is spent in unpaid work such as cooking, housework, maintenance and repair, shopping or caring for a spouse. Twelve hours is spent in personal care including sleeping, bathing, dressing, toileting, and eating.[29]

VOLUNTEERING AND COMMUNITY PARTICIPATION

Seniors with disabilities play an important role in community life, and a significant number offer their personal time, experience and energy as volunteers through community organisations.

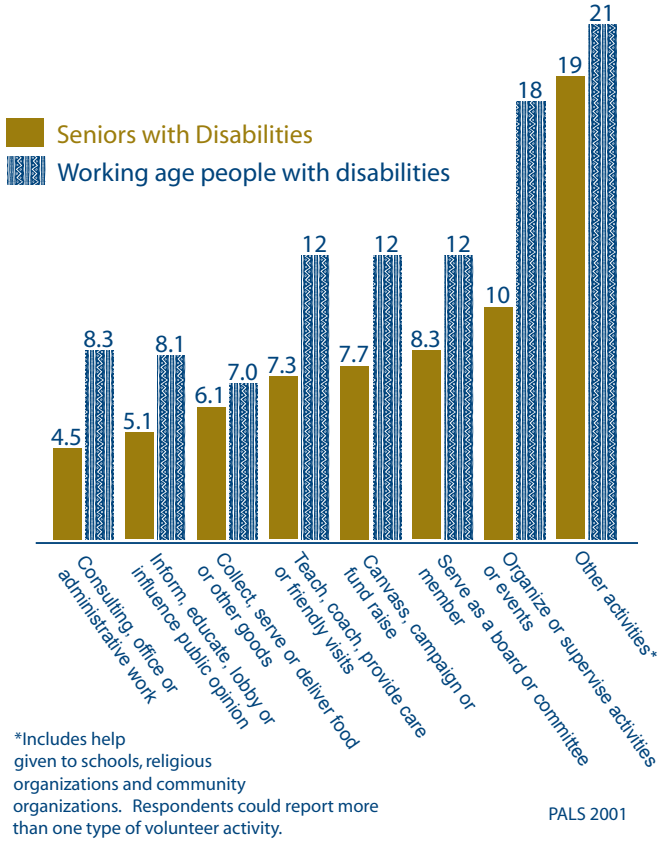
21% of seniors with disabilities are active volunteers in their communities compared to 18% of all seniors who volunteer

According to the National Survey of Giving, Volunteering and Participating (NSGVP), some 6.5 million or 27% of all Canadians volunteer including 18% of all seniors.[30] By comparison, 21% of seniors with disabilities reported volunteering in the 2001 PALS, including 27% of those 65-74 years of age and 17% of those 75 years of age and over.

Differences in the two surveys make it difficult to compare the types of volunteer activities by seniors with and without disabilities. For three types of volunteering that appear in both surveys—serving as an unpaid board member; canvassing, campaigning, fundraising; and collecting, serving or delivering food or other goods—the rates of volunteering among seniors with and without disabilities appear to be similar.

As shown in Figure 3.1, the types of volunteer activities of seniors with disabilities generally mirror those of younger adults with disabilities, though at lower levels of participation.

3.1 Volunteer activities through formal organizations (%)



*Includes help given to schools, religious organizations and community organizations. Respondents could report more than one type of volunteer activity.

PALS 2001

VOLUNTEERING

Theresa, who will be 87 on her next birthday, was an active volunteer at her local hospital for over 21 years. While she's "retired" from the hospital, she's still active with various clubs at her church despite recent cancer surgery and the ongoing need to manage health complications that have come with being a diabetic.[31]

Discussion of participation in formal voluntary activities for seniors with disabilities does not fully account for their volunteer activity. Much of the volunteering is done informally —without the channel of formal organizations—and is difficult to quantify. For example, seniors with disabilities providing care to their own partners or family members may go under-reported. Data from the General Social Survey of 2002 provides some insight, finding that 10% of those 65-74 years of age and 6.1% of seniors 75 years of age and over are providing informal care for a long-term health problem to someone who is also 65 years of age or over.

BOX 3.2 NEW HORIZONS PROGRAM

The New Horizons Program for Seniors has funded the Rose Valley Seniors' Town Beautification Project in Saskatchewan, a community beautification project involving all generations including youth, students, seniors and people with disabilities. The volunteer committee is chaired by seniors who are involved in all phases of the project, from fundraising through to design and landscaping. The project celebrates the values of civic pride and voluntarism and has given the community a pleasant park for seniors and future generations to enjoy.

EMPLOYMENT RATE

With the aging of the population, improved health among seniors and repeal of mandatory retirement legislation in some jurisdictions, seniors represent a growing portion of the labour force,[32] with some seniors with disabilities being part of that group. Changes to mandatory retirement legislation, such as recent changes in Ontario, mean that more seniors with disabilities may reconsider traditional retirement options.

For some seniors, work continues to provide social contacts, helping to reduce isolation; it may fill income gaps from interrupted labour market participation during their working-age years; or, it may simply help meet current living expenses.[33]

In 2003, 11% of seniors 65 to 69 years of age with disabilities were employed all year in comparison to 16% of their age-peers without disabilities

Data reported from PALS in the 2004 report showed that the likelihood of workers with disabilities 55 to 64 years of age remaining in the labour force is significantly lower than that of younger workers. Nonetheless, the Survey of Labour and Income Dynamics shows that in 2003, 11% of seniors 65 to 69 years of age with disabilities continued to be employed all year in comparison to16% of their age-peers without disabilities.[34]

Rather than full-time work, working part time may provide the flexibility to extend participation in the workforce while addressing aging issues and disability-related needs. Figures for full-time and part-time status are not available for seniors with disabilities. However, for seniors 65 to 69 years of age in total, approximately 7.1% worked full-time all year in 2003, while 4.9% worked part-time for the full year. [35]

The significant number of employed seniors with disabilities underlines the importance of ensuring that the work environment and the nature of the work accommodate their needs. Flexible work scheduling is one of the principal ways that seniors with disabilities can be accommodated at little or no cost. Physical work or repetitive movements may have a significant impact on senior workers' bodies, and keeping safe and free of injury requires an appropriately designed workplace. This principle applies to all workers, but senior workers tend to have more severe injuries when they do get injured.[36]

CONCLUSION

This brief look at volunteering and employment demonstrates clearly that many seniors with disabilities actively participate in their community. The research suggests that seniors with disabilities may be even more likely to volunteer than their peers without disabilities. Together with other less visible and more private forms of participation, significant numbers of seniors with disabilities are showing that active living is a goal that can be achieved.

As will be seen in the next chapter, however, some seniors with disabilities may be prevented from engaging in the activities of their choice by a lack of needed supports.

GOVERNMENT ACTION SUPPORTING COMMUNITY PARTICIPATION OF SENIORS WITH DISABILITIES

PUBLIC HEALTH AGENCY OF CANADA

- Physical Activity Contribution Program*
- *Population Health* Fund

SOCIAL DEVELOPMENT CANADA

- New Horizons for Seniors Program*

* These programs are only partially targeted to people with disabilities. See the discussion of "partially-targeted measures" in Chapter 9.

CHAPTER 4
DISABILITY SUPPORTS

HIGHLIGHTS

- 7 in 10 seniors with disabilities have all the assistive aids and devices they need
- The majority of seniors with disabilities receive help for everyday activities from family members
- 5 in 10 women with or without disabilities aged 75 years and over live alone
- There is a growing demand for caregivers at a time when the supply is diminishing
- Some caregivers for seniors with disabilities may need support due to their own aging
- Increasingly, aging parents are the primary caregivers of an adult child with disabilities
- Older people living in their own homes are more likely to have an unmet need for adaptations to their home

BOX 4.1 TOOLS FOR INCREASED PARTICIPATION: AN EXAMPLE

Peter is a 75-year-old Veteran who was severely paralyzed in a car accident: "At first, I was very wary of trying new gadgets and aids. I felt it made me look vulnerable." With time, Peter learned to navigate his wheelchair with art. He also learned to use the computer to write because of his weak right hand and acquired many of the bathroom and kitchen aids that facilitate his daily activities. He started to use Meals On Wheels and has become great friends with the senior who makes the deliveries. He returned to his volunteer work with students at his local library when, at his request, the library had the three-step entrance made level and provided facilities for him to use the washroom. He now enjoys his students again and feels very much part of the community.[38]

DISABILITY SUPPORTS are the goods and services that people with disabilities need to fully participate in daily life. They are important to help individuals develop personal independence, but significant numbers of people are not able to have access to all the supports they need.

Obstacles to getting needed supports go beyond availability and affordability. Some seniors experiencing disability as a result of aging may not seek the "disability supports" they need, due to the stigma they associate with disability. For example, some believe using a wheelchair is a sign of frailty, but more seniors are using scooters to move around in public spaces. It seems that having a scooter is not associated with disability but rather with aging, making it more socially acceptable—although both devices achieve the same purpose of increasing mobility.[37] People aging "into" disability may be less able to draw on support networks and may be unaware of how to access the supports delivered through organizations serving the disability community.

This chapter presents a series of indicators measuring how seniors with disabilities have their needs for supports met. It includes information on individual supports such as aids and devices, help needed for everyday activities and home modifications. As well, it addresses supports to informal caregivers and accessibility of the environment, including transportation and information. These indicators are supplemented to present a more complete portrayal of the needs of seniors with disabilities. For example, because of the increased need for medication by many seniors, a brief discussion around medication supports supplements the core indicator for *aids and devices*. The core indicator *home modifications* has been expanded to discuss further housing issues relevant to seniors with disabilities.

INDICATORS

BOX 4.2 INDICATORS OF DISABILITY SUPPORTS

- Aids and devices needed for everyday activities
- Help needed for everyday activities
- Supports for family caregivers
- Home modifications
- Transportation
- Information in multiple formats

Supplemental Indicators

- Medication support
- Housing

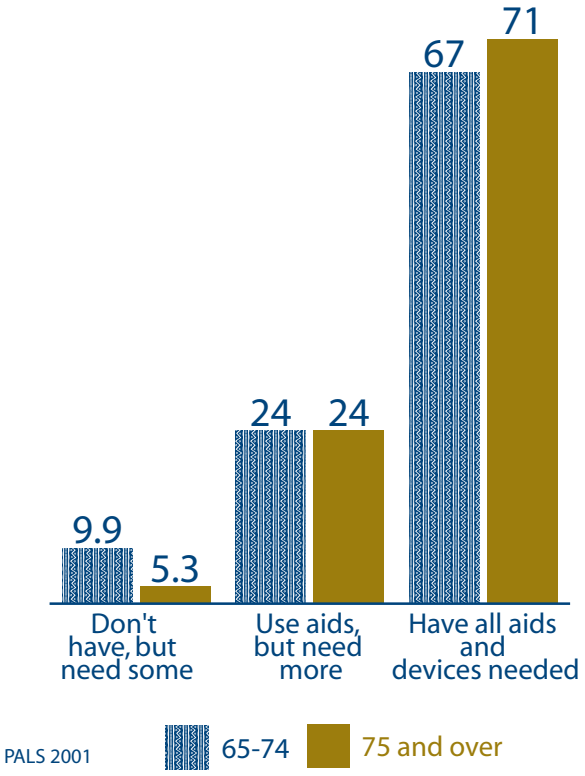
AIDS AND DEVICES NEEDED FOR EVERYDAY ACTIVITIES

7 in 10 seniors with disabilities have all the assistive aids and devices they need

Assistive aids and devices include any type of equipment or aids that help people with disabilities with everyday tasks and activities. Examples include motorized scooters, hearing aids and service animals. In Canada, the most commonly needed technical equipment or assistive aids are those designed to assist with disabilities usually associated with aging, such as mobility and hearing disabilities.

In 2001, an estimated 2,008,000 adults with disabilities require some type of assistive aid or device. Of those, 657,000 or 33% did not have their needs fully met. Seniors—particularly those over 75 years of age—are more likely to need assistive aids and devices than younger people—representing almost half (48 %) of overall requirements. At the same time, compared to others, seniors are more likely to have these needs fully met. Within the seniors population, women are more likely to require supportive aids and devices, but they also have fewer unmet needs. Figure 4.1 indicates that younger seniors (those 65-74 years of age) are less likely to have their requirements fully met. In particular, about 10% had none of their needs for aids or devices met in contrast to 5% of older seniors. However, as reported in 2004, seniors fare better than working-age people with disabilities where, among those needing aids and devices, approximately 25% have none of what they need.[39]

4.1 Use and need for aids and devices for seniors with disabilities (%)



The reasons why seniors with disabilities do not have all their needs met are complex. The most common barriers cited are cost and lack of insurance; other reasons include lack of information about where to find them and some reluctance of seniors aging into disability to obtain the aids. For many seniors, there is a strong stigma associated with the use of such aids, as it is seen as a symbol of diminished capacity.

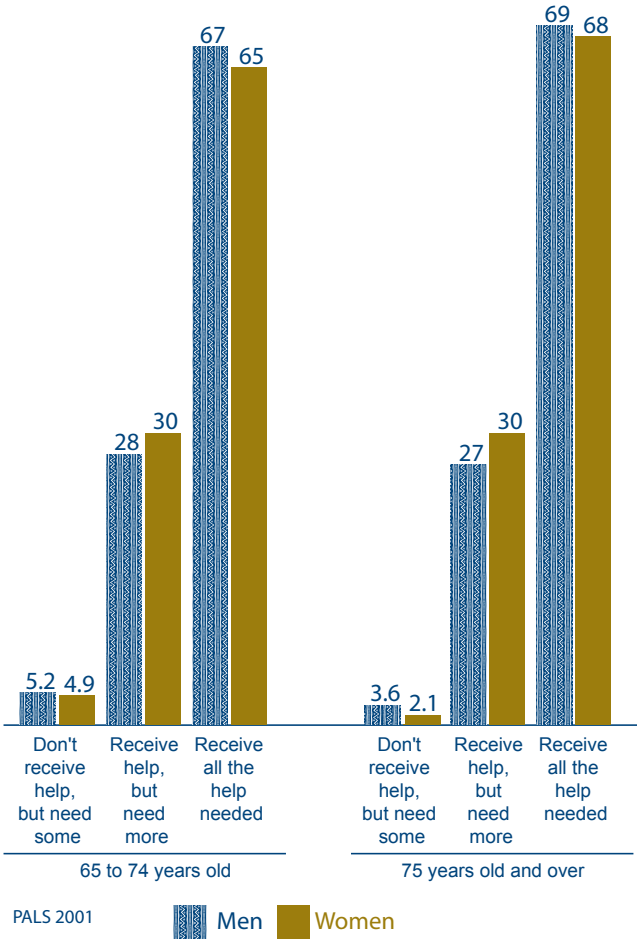
MEDICATION SUPPORT (SUPPLEMENTAL INDICATOR)

Medication support is of particular importance for this age group, because both senior men and women with disabilities are more likely than other adults with disabilities to report using medication regularly. Almost 85 % of senior men with mild disabilities reported using medication at least once a week, compared with 90% of senior women with mild disabilities. These figures increase to 94% for men and 95% for women with severe to very severe disabilities.[40] Some 95% of seniors with disabilities are able to get the medication or drugs they are supposed to use. However, the remaining 5% cannot get them due to cost, with women representing almost 70% of these seniors.[41]

Most Canadians have coverage for prescription drugs from one source or another.[42] They receive drug coverage from government programs, private individual plans or via their employers. However, there are wide variations in plan design, eligibility criteria and out-of-pocket costs. For people covered by government plans, the responsibility is largely that of provincial and territorial governments, with substantial regional differences in drug coverage, especially for coverage against catastrophic drug expenses. The Government of Canada, through various programs, funds prescription drug coverage for about one million Canadians—including many seniors with disabilities—who are First Nations and Inuit, members of the military, Veterans, members of the RCMP, and inmates in federal penitentiaries. Also, as an employer, the Government of Canada provides prescription drug coverage to retired and active federal public servants.

HELP NEEDED FOR EVERYDAY ACTIVITIES

4.2 Use of and need for help with every day activities for seniors with disabilities (%)



Like younger people with disabilities, seniors with disabilities may also need some assistance with activities of everyday life. Most of this assistance takes the form of meal preparation, errands and transportation to appointments, housework, specialized nursing or medical treatments, personal care and help getting around the home. About 69% of Canadian seniors with disabilities receive all the help they need while approximately 24% receive a portion of needed assistance. Similar to the situation for aids and

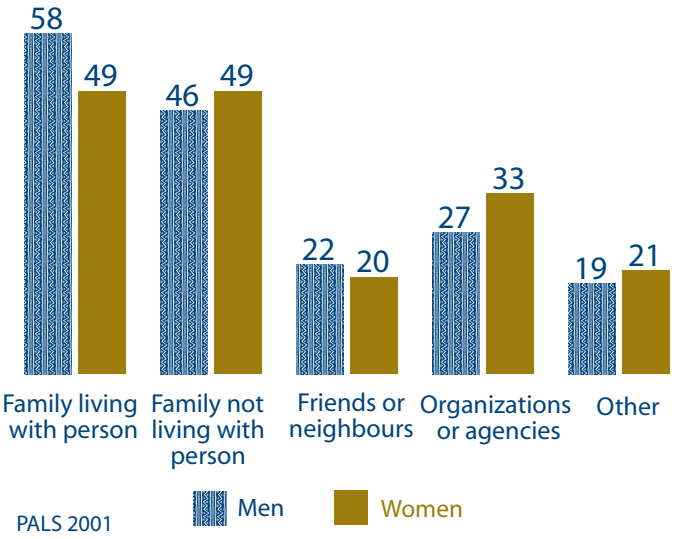
devices, younger seniors are less likely to have their needs for assistance with activities of daily living fully met (see Figure 4.2). As reported in the 2004 report, working-age adults with disabilities are even more likely to have none of their needs met—7.5% do not have any of the assistance with daily activities that they need.

Data show that men and women have very similar patterns of need for help with everyday activities. However, senior men with disabilities are more likely to be receiving help from their wives than the other way around.

The majority of seniors with disabilities receive help for everyday activities from family members

As shown in Figure 4.3, help needed for everyday activities for seniors with disabilities is generally provided by family members, either living with the person (58% for men and 49% for women) or living elsewhere (46% for men and 49% for women).

4.3 Source of help with everyday activities for seniors with disabilities receiving help (%)



PALS 2001

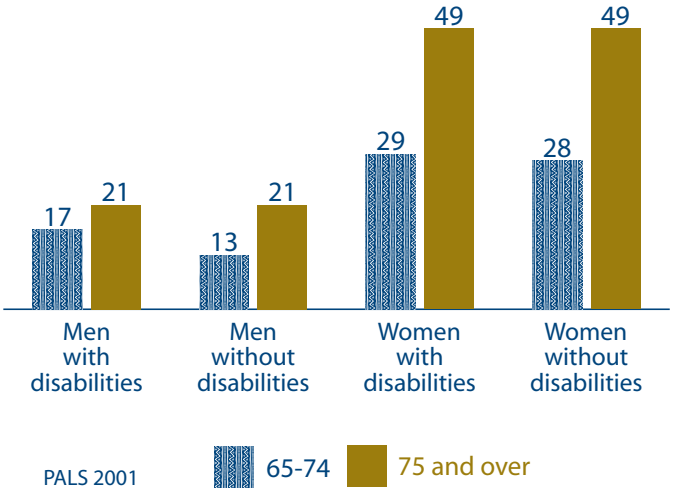
Approximately 21% of seniors with disabilities 65 to 74 years of age and 38% of seniors with disabilities 75 years of age and over receive help from formal service providers such as organizations and agencies. Most of this help comes in the form of specialized nursing and medical treatment.

Of those who do not have the help they need, cost and lack of insurance coverage are the most significant barriers. Among those who do find the supports they need, a significant number indicate problems with delays, costs and finding qualified help (45%, 43% and 42% respectively).

5 in 10 women with or without disabilities aged 75 years and over live alone

Seniors may depend on relatives living elsewhere or formal services for assistance because they frequently live alone. As shown in Figure 4.4, senior women, both those with and without disabilities, are more likely to live alone than are senior men. Most of these women live as widows, reflecting longer life expectancy and a tendency to enter married life at a younger age than their husbands. As a result, 5 in 10 (49%) women with or without disabilities aged 75 years and over live alone.

4.4 Seniors living alone (%)



PALS 2001

SUPPORTS FOR FAMILY CAREGIVERS

Family and other unpaid caregivers provide services critical to maintaining independence at home for seniors with disabilities, as well as those with chronic and acute care needs or who require support because of physical, cognitive or mental health conditions. More and more

Canadian seniors are receiving care in their own home, often from a family member but also from friends and neighbours. The General Social Survey (2002), indicates that almost 20% of Canadians over 45 years of age were providing informal care to one or more family members or friends over 65 years of age.

Caregiving tasks include activities of daily living, personal care, monitoring and emotional support. Time spent in caregiving can be substantial depending on the type of care provided. For instance, caregivers 45-64 years of age who are caring for seniors spent on average 23 hours per month providing care.[43] It has been estimated that informal caregivers provide more than 80% of all home care needed by people with long-term health problems.[44]

The growing need for cargivers may overwhelm the ability of families and friends to respond

Family caregiving is not a new phenomenon. What has changed are the circumstances under which families are providing care. There is a growing need for caregiving at a time when families and friends may not be able to respond adequately. Increased need for care at home results from a number of socio-economic and demographic trends, including an aging population, rapid technological advancements leading to more care at home and a general preference for community living. Simultaneously, having more women in the workforce, and families that are smaller, less traditional and more dispersed leads to a reduced capacity of families to provide care.

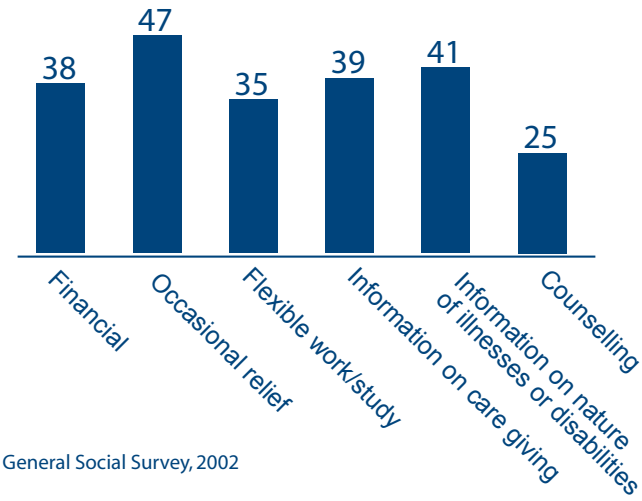
Canadian families face challenges balancing their multiple roles (e.g. for earning, child rearing and caregiving) and these challenges will likely grow. The demographic projections in this report estimate that seniors could make up as much as 54.3 % of the population of people with disabilities by 2026. At the same time, the demand on working-age adults to provide support to “dependent” individuals will significantly increase.[45] With the ratio of seniors with disabilities to working-age adults rising from 18.5% in 2001 to 34.0 % in 2026, working-age adults at that time may experience a significant challenge in meeting their caregiving responsibilities.[46]

While caregiving is often a rewarding experience, there is more and more evidence of significant and often hidden costs associated with providing care. Some of these costs are economic, but many are not. For example, a considerable number of caregivers face a constant challenge trying to balance work, their own health needs and caregiving responsibilities. A large proportion of caregivers, especially women, subsequently reduce work hours, or leave employment altogether, for caregiving reasons. This has both immediate and long-term economic repercussions.

Many caregivers also have children living at home. In 2002, about 712,000 Canadians 45-64 years of age with children at home (also referred to as the «sandwich generation») performed some type of care for seniors, and of these 589,000 (approximately 83%) were also employed.[47]

As shown in Figure 4.5 below, some 5 in 10 (47%) informal caregivers 45 to 64 years of age want occasional relief. Caregivers also need information on caregiving and on the disability or illness of the person for whom they are providing care. Financial compensation and

4.5 Needs of family caregivers 45-64 years of age (%)



General Social Survey, 2002

flexible work arrangements are also requested by a significant number of caregivers (38% and 35% respectively). And, one-quarter (25%) of all informal caregivers want counselling. These key issues were confirmed by stakeholder groups during various consultations between January and June 2005 on issues related to family caregiving, conducted by the Minister of State for Families and Caregivers.

Some caregivers of seniors with disabilities may need support due to their own aging

People who have been providing care to a partner or parent with disabilities can face difficulties in providing the appropriate quantity and quality of care, due to their own declining energy or increased frailty. According to the General Social Survey 2002, some 185,000 or 9% of women and 131,000 or 8.1% of men 65 years of age and over were providing care to another senior due to a health condition. Of these, some 11% said that caregiving had affected their own health.

Increasingly, aging parents are the primary caregivers of an adult child with disabilities.[48]

When parental health or disabilities make caregiving in the parental home no longer possible, planning for supportive housing or placement in a long-term care facility may become necessary, both for the adult child and the parents. In such cases, where everybody's needs must be considered, support services for seniors with disabilities, adequate housing and caregiving issues must be dealt with together.[49]

BOX 4.3 THE CHALLENGE OF AGING FAMILY CAREGIVERS: AN EXAMPLE

For over 50 years, Jacques and Lucie assisted their daughter Helene as she developed increasingly severe disabilities, including blindness, osteoporosis and kidney disease. With dialysis three times a week, Helene lived with her parents and was fully dependent on their support for many activities of daily living. However, in 2003, Lucie, who had been the main caregiver, developed cancer at age 82 and passed away. Helene and Jacques were not able to care for themselves and both moved to an assisted living residence.[50]

HOME MODIFICATIONS

Older people in their own homes are more likely to have an unmet need for adaptations to their home

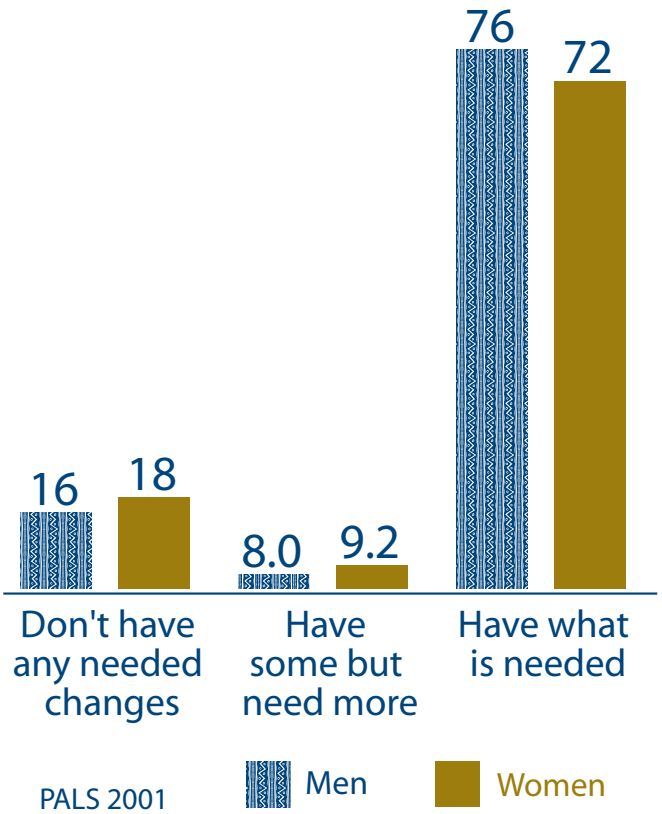
Home modifications are any form of adaptation made to living space to enhance the independence and safety of those who live there. These special features may include low counters, ramps, grab bars, larger hallways and labelled kitchen cupboards to remind people of their contents. About half of all adults who need home modifications are seniors. As illustrated in Figure 4.6, the majority of seniors with disabilities have what they need (72% of women and 76% of men). In contrast, as shown in the 2004 report, only half of working-age adults with disabilities who need home modifications have all that they need.

BOX 4.4 RESIDENTIAL REHABILITATION ASSISTANCE PROGRAM — SECONDARY/GARDEN SUITE PROGRAM ANNOUNCED

The Residential Rehabilitation Assistance Program — Secondary/Garden Suite offered by the Canada Mortgage and Housing Corporation was announced in May 2005 to assist in the creation of affordable housing for low-income seniors and adults with a disability by providing financial assistance to convert/develop existing residential properties that can reasonably accommodate a secondary self-contained unit.

Cost is the prime reason for seniors to have unmet needs for home modifications. The most common requirements for home modifications are grab bars and bath lifts for the bathroom, followed by ramps, accessible elevators, doors and hallways. The percentage of seniors with disabilities needing specialized features in the home increases from 15% to 23% between those 65-74 years of age and those age 75 and over. Older people living in houses that they own are much more likely to have unmet needs for adaptations.

4.6 Use of and need for specialized features at home for seniors with disabilities (%)



HOUSING (SUPPLEMENTAL INDICATOR)

Having adequate and supportive housing for seniors with disabilities goes beyond having the right specialized features in the home. Other factors play an important role in improving their living arrangements. The feeling of "home" can make a significant difference in psychological and emotional comfort. And, while safety and accessibility in the home are key, the accessibility of services, social and recreational activities also contribute to well-being and participation.

❖

"It's home…it's security. I know, as long as God gives me the health, that I have a place to stay…. Well, yeah, I love my home. Well, wouldn't you, if you worked from scratch for it?"[51]

People have different needs, preferences and disability issues, making it essential to have flexibility in housing options. Housing arrangements designed to improve the availability of needed supports and services can facilitate community living for seniors with disabilities.

The housing market is evolving and responding to the growing demand for residential arrangements to meet the housing needs of seniors with disabilities. Housing options range from those supporting independent living (desired by those who are able to manage or direct the support services they may need) to full institutional care facilities.

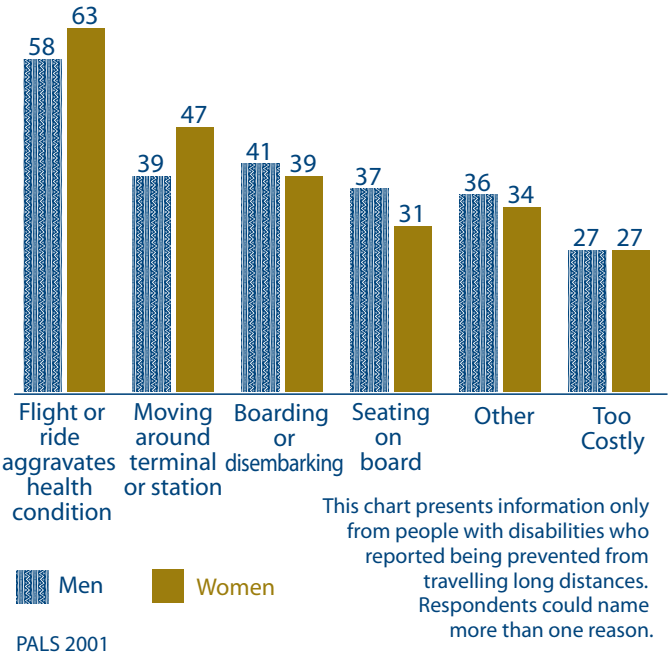
If independent living is no longer possible, the need for formal supportive caregiving can be met through transitional or graduated-care facilities. Some of these are guided by the

s*upportive housing* principle. Supportive housing assists seniors in their daily living by combining a physical environment that is specifically designed to be safe, secure, enabling and home-like with support services such as meals, housekeeping, social and recreational activities. This helps residents maintain independence, privacy, dignity and decision-making. This type of housing option includes residential character, a supportive physical environment, access to necessary support services, a progressive management philosophy, as well as affordability and choice.

Services can be provided through a combination of on-site and off-site arrangements and can be made available to both residents and other older people living in the surrounding neighbourhood. Highly service-enriched supportive housing, such as assisted living, can be an alternative to institutional care.

When the level of care required surpasses what informal caregiving and formal care delivered at the community level provides, managed care in hospitals or nursing homes may be necessary to meet the needs of some seniors with disabilities.[52]

4.7 Major barriers preventing seniors with disabilities from travelling long distances (%)



This chart presents information only from people with disabilities who reported being prevented from travelling long distances. Respondents could name more than one reason.

PALS 2001

BOX 4.5 SUPPORTIVE HOUSING FOR SENIORS: AN EXAMPLE

The Abbeyfield House concept provides a supportive environment for single seniors in their home community. Living in adapted homes like a large family, each resident has a private bedroom/sitting room with its own en-suite washroom. This private space is furnished with the resident's own belongings.

Communal areas in the house include a lounge for watching television or other social interaction with friends and relatives, as well as a dining room where residents gather twice a day for common meals. Some Abbeyfield Houses also include an activity room.

Unlike a nursing home, Abbeyfield housing is geared to seniors who are in relatively good health but are no longer willing or able to live alone. Each local Abbeyfield Society is a group of volunteers that initiate, support and guide the operations of the Abbeyfield House through a board of directors. Service clubs, church groups or legions often start local Abbeyfield Societies. For example, in the United Kingdom more than 200 Abbeyfield Houses have been developed by Rotary Clubs.[53]

TRANSPORTATION

According to a recent Transport Canada study[55], detailed demographic projections of the Canadian population between the years 2000-2026 reveal significant implications for an aging Canadian population on accessible transportation services. Estimates of future rates of mobility restrictions shows that the age groups that will experience the most dramatic increase will be adults 65-74 years of age and those 75 and over.

Barriers preventing seniors from travelling long distances were identified in the PALS survey. Figure 4.7 shows that 6 in 10 (58% of men and 63% of women) seniors with disabilities do not travel long distances because the flight

BOX 4.6 TRANSED 2007

Transport Canada will host the 11th International Conference on Mobility and Transport for Elderly and Disabled People (TRANSED) entitled "Benchmarking, evaluation and vision for the future" from June 18-21, 2007 in Montréal. This event, which is expected to attract over 300 participants, will allow international experts to exchange ideas as well as innovative and technological solutions for the transportation needs of an aging population and of people with disabilities and special needs.[54]

or the ride aggravates their condition. Almost 5 in 10 women (46%) and 4 in 10 men (38%) who are prevented from travelling have difficulty moving around the terminal or station. Boarding or disembarking is an issue for 4 in 10 seniors with disabilities who cannot travel long distances. Seating arrangements and cost are also barriers to travel. Disability advocates believe that long distance travel for some people with disabilities such as people who use wheelchairs has actually become more difficult in recent years.

When it comes to local travel, approximately one-third of seniors with disabilities need to use public transit. However, approximately 5% are prevented from travelling locally by public transportation and another 10% experience difficulty. The most common barriers reported are getting on or off vehicles (48 %), getting to or locating bus stops (32 %) and service not available all the time (26%). Senior women with disabilities are more likely than men to need public transit and to experience barriers. As well, seniors 75 years of age and over are more likely to need public transport and to experience problems than younger seniors.

While almost all seniors with disabilities indicate a need to travel locally by car, about one in 10 is prevented or has difficulty in doing so. Reasons cited by seniors with disabilities for being prevented from travelling locally by car are the need to have an attendant (32%), the lack of space for wheelchairs or other specialized equipment (16%) and the lack of proper equipment in the car (9.5%).

❖

"We are all getting older. Transportation is more difficult. Some of those who can no longer drive don't like to ask for help and sometimes they don't know where to ask. We need to help people have access to services that are available".[56]

INFORMATION IN MULTIPLE FORMATS

There are a number of different types of disabilities and health conditions that may make conventional print information difficult or impossible to access. Fully-inclusive environments require easy and universal access to information in multiple formats. Technology developments in recent years have provided people with disabilities with a growing variety of means to create and share information. Specialized computer software, screen magnification, voice recognition systems and other electronic devices are now part of the lives of many people with disabilities. However, information transmission in electronic formats and on computerized equipment may not be appropriate in the case of seniors with disabilities. Among seniors with disabilities, only 11 % use a computer and 6.6 % use Internet at least once during a year.[57]

CONCLUSION

Disability supports provided directly to individuals and in the form of accessible environments are the foundation for full participation by seniors with disabilities. This review has shown that the majority of seniors have the supports they require, however, there are some significant gaps and specific issues.

The evidence presented suggests that younger seniors may be less likely to have the support they require than older seniors. Both

younger and older seniors, even though they are more likely to need supports, are more likely to have their needs met than are working-age people with disabilities. Financial barriers are most often cited as the reason for not having what is needed, but reluctance to acknowledge the presence of a disability may also play a factor.

There is not a significant difference in access to supports for men and women, however, when it comes to personal assistance, men are more likely to rely on family members such as wives and children to help them than are women. The primary reason for this is the longer life expectancy of women and the gradual loss of informal sources of support as they grow older. Looking to the future, a source of concern is a potential shortage of informal caregivers as the number of seniors with disabilities will increase at a greater rate than the numbers of younger family members.

GOVERNMENT ACTION ADDRESSING AVAILABILITY OF DISABILITY SUPPORTS FOR SENIORS WITH DISABILITIES

CANADA MORTGAGE AND HOUSING CORPORATION

- Home Adaptations for Seniors Independence
- Residential Rehabilitation Assistance Program for Persons with Disabilities
- Residential Rehabilitation Assistance Program—Secondary/Garden Suite
- FlexHousing™
- Housing Options for People with Dementia (Guide)
- Research to encourage innovation in seniors housing*

CANADIAN HUMAN RIGHTS COMMISSION

- Study of availability of Government of Canada services for hearing impaired people

CANADIAN TRANSPORTATION AGENCY

- Regulations regarding accessibility of modes of transportation under Federal jurisdiction
- Assistance to travellers with disabilities
- Development of a Code of Practice regarding transportation terminals in the Federally regulated transportation system*

FINANCE CANADA/CANADA REVENUE AGENCY

- Disability Supports Deduction
- Medical Expense Tax Credit*

PUBLIC HEALTH AGENCY OF CANADA

- Division of Aging and Seniors—public awareness and health promotion activities*

TRANSPORT CANADA

- *Straig*ht Ahead policy statement*
- National Workshops for Driver Rehabilitation Specialists (2002 and 2004)*
- Research on in-vehicle intelligent transportation systems*

VETERANS AFFAIRS CANADA

- Veterans Independence Program
- Gerontological Advisory Council*
- *Continuing Care* Research Project (with the Ontario Seniors Secretariat)
- *Seniors Canada Online* and the Collaborative Seniors Portal Network (with the Government of Ontario and four communities)*

* These programs are only partially targeted to people with disabilities. See the discussion of "partially-targeted measures" in Chapter 9.

CHAPTER 5
HEALTH AND WELL-BEING

HIGHLIGHTS

- For people with and without disabilities, active living can maintain independence and autonomy throughout the course of a lifetime
- Seniors with disabilities are much more likely to indicate that their health is fair or poor
- Seniors having both a chronic condition and disabilities are particularly at risk of having poorer health
- Seniors reporting both disabilities and mood disorders have significantly poorer health than any other group of seniors
- The beneficial effects of social support on health are greater for seniors with disabilities than for those without disabilities
- Falls continue to be the most frequent injury among seniors with disabilities
- Compared to seniors without disabilities, the link between physical activity and better health is stronger for seniors with disabilities
- The positive link between income, education and health is stronger among seniors with disabilities than for those without disabilities
- Failure to receive needed health care has a greater negative impact on the health of seniors with disabilities than on seniors without disabilities

With appropriate supports, seniors with disabilities can have a quality of life equal to that of seniors without disabilities

THE LINKS between aging, disability and health are complex. However, there is an essential distinction between aging as a healthy process of the life cycle and "pathological aging" caused by injuries or health conditions that may lead to disabilities.

The World Health Organization (WHO) defines health as more than just the absence of illness or disease. It also includes mental, physical, social well-being, and the capacity to function fully in an environment. The International Classification of Functioning, Disability and Health (ICF) defines disability as the result of interaction between contextual factors (environmental and personal) and health conditions that translates into activity limitations and participation restrictions. Although sometimes poor health and aging can lead to disability, the opposite is not necessarily the case.

For people with and without disabilities, active living can maintain independence and autonomy throughout the course of a lifetime

According to the WHO, a key goal for seniors is to remain independent and autonomous.[58] As people with disabilities age, their health and level of independence can be compromised by chronic conditions, mental conditions, traumas, individual behaviour and environmental factors. On the other hand, choices, behaviours and environments can enable the full development of physical, mental and social potential as people age. Using the concept of aging as a process, the WHO talks about "active aging." It is possible to prevent or delay the onset and development of illnesses and chronic conditions through active living. As discussed in Chapter 4, for seniors with disabilities it may be helpful to integrate insights associated with active aging with those of the independent living movement.

This chapter focuses on the identification of several factors that can have an impact on health and well-being of seniors with disabilities and gives a perspective on the determinants of « successful aging ». The chapter also explores the various effects on quality of life of health conditions caused by aging and those having other causes.

INDICATORS

BOX 5.1 INDICATORS OF HEALTH AND WELL-BEING

- Health Status
- Impact of chronic conditions
- Impact of mental conditions
- Impact of violence and neglect
- Impact of injuries
- Impact of individual behaviour factors
- Impact of environmental factors

Supplemental Indicator

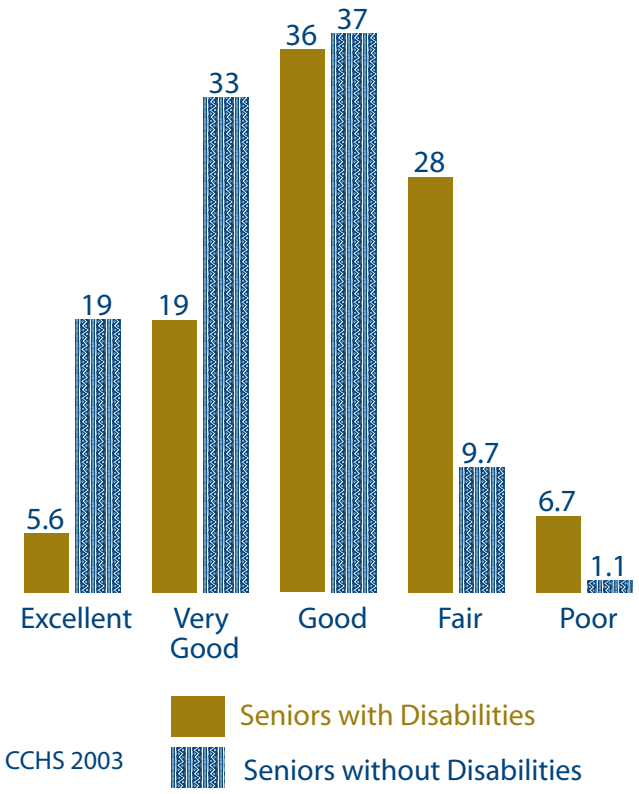
- Health-related quality of life

HEALTH STATUS

Seniors with disabilities are much more likely to indicate that their health is fair or poor

Self-rated health status is one of the most common ways to evaluate health. People with disabilities who respond to a survey are invited to evaluate their own health according to a scale: excellent, very good, good, fair, or poor. As Figure 5.1 indicates, seniors with disabilities are much more likely to indicate that their health is fair or poor (35% declare that their health is fair to poor, compared to 11% of other seniors). As reported in 2004, a similar pattern occurs for the entire adult population as younger adults with disabilities are also more likely to report fair or poor health than those without disabilities. For both those with and without disabilities, seniors are more likely to rate their health lower on the scale than working age people.

5.1 Self-reported health of seniors (%)



IMPACT OF CHRONIC CONDITIONS

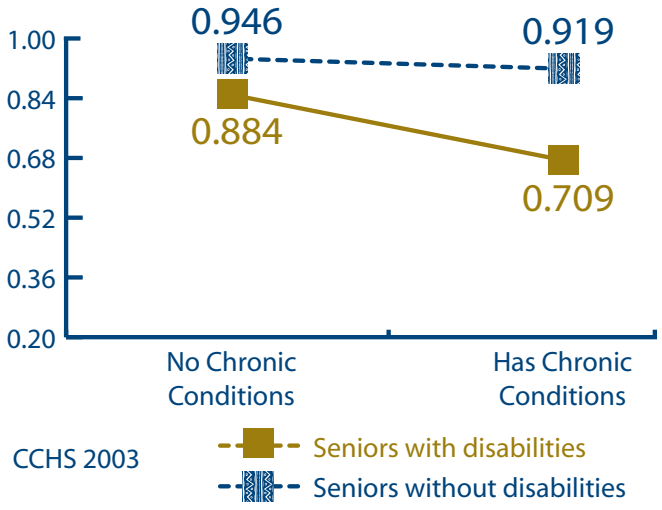
Research shows that factors such as chronic conditions,[59] mental and psychological conditions, trauma, individual behaviour and socioeconomic factors can each have an impact on health. The Government's 2004 report on people with disabilities explored the links between these factors and the health status of people with disabilities who are 15 years of age and over.[60] This year's report examines the same links for seniors in more detail.

To examine these relationships, health is measured using the McMaster University Health Utility Index (HUI™),[61] the same index used in the 2004 report.[62] The HUI is an index that measures the functional aspects of physical, mental and emotional health. HUI values above 0.8 are generally considered to represent very good to excellent health.

Seniors having both a chronic condition and disabilities are particularly at risk of having poorer health

Many chronic conditions can lead to disabilities in the long term including activity limitations and participation restrictions. In the 2004 report, data from the Canadian Community Health Survey (CCHS) indicated that 87% of people with disabilities also reported chronic conditions.[63] There was an even stronger relationship for seniors—96% of people with disabilities 65 years of age or over have chronic conditions. Measured by the HUI, the functional health status of seniors with both disability and chronic conditions is significantly poorer (HUI=0.709) compared to that of seniors with disabilities having no chronic condition (HUI= 0.884) and it falls below the threshold of 0.8 representing very good or excellent health. Seniors without disabilities have better health overall, however some deterioration in functional health is observed for those reporting chronic conditions.

5.2 Chronic conditions and the Health Utility Index (HUI)



"I was having trouble just, you know, getting up. The lady said something about arthritis, and I said, 'It isn't the arthritis, it's my old age that bothers me.' She then said, 'Oh, what are you, about 75 or 76 years old?' I said: 'No, I'm 90 years old, past!'[64](Hannah, 90)

IMPACT OF MENTAL CONDITIONS
COGNITIVE AND EMOTIONAL DISORDERS

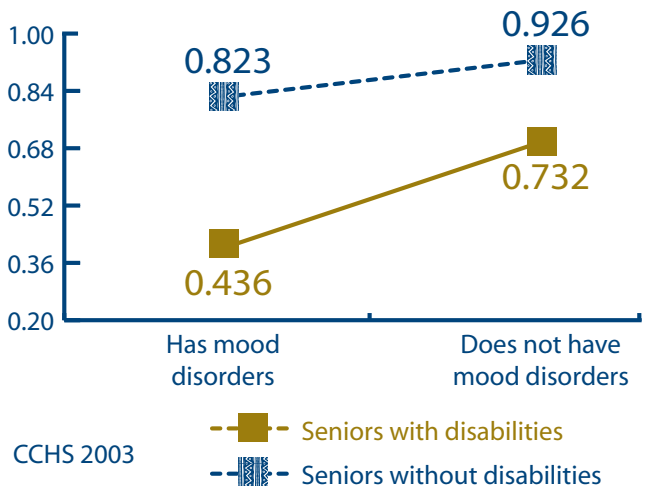
Seniors reporting cognitive or emotional disorders are more likely to have participation restrictions affecting their social life

Mental conditions can affect anyone, regardless of education, income, or ethnic background. Many interdependent factors can lead to the development of mental illnesses. For example, people with chronic physical health problems often end up experiencing anxiety or depression.

Understanding the magnitude and effects of mental illness or of learning, cognitive, and memory ailments is difficult using survey data because seniors are very unlikely to self-report these conditions. In the CCHS, only 0.8% of seniors report these types of limitations. Still, analyses of the CCHS indicate that those seniors reporting cognitive or emotional disorders are respectively 1.27 and 1.45 times more likely to report having participation restrictions affecting their social life. According to the same source, the health status of seniors reporting an incapacity and mood disorder is worse than the health status of seniors who have neither and is substantially below the threshold marking good health (the HUI is respectively 0.436 and 0.732) (see Figure 5.3).

A particular reason to examine mental health problems among seniors is their possible link to deterioration of cognitive ability. According to the WHO, "often, the deterioration of cognitive functions is caused by the lack of use (lack of

5.3 Mood disorders and the Health Utility Index (HUI)



practice), illness (depression for example), behavioural factors (such as the use of alcohol and medications), psychological factors (such as the lack of motivation or having low expectations), the lack of confidence and social factors (solitude and isolation for example), rather than aging in itself."

Mental health promotion is an important avenue for improving the mental health of seniors with disabilities. Mental health promotion can be understood as the process of enhancing the capacity of individuals and communities to take control over their lives and improve their mental health. By working to increase self-esteem, coping skills, social support and well-being in all individuals and communities, mental health promotion empowers people and communities to interact with their environments in ways that enhance emotional and spiritual strength.[65]

BOX 5.2 REPORT ON SENIORS' FALLS IN CANADA

On November 7, 2005 PHAC released the Report on Seniors' Falls in Canada. This report presents a comprehensive analysis of national data for Canadians 65 years of age and over on fall injuries and deaths, as well as evidence on risk factors and best practices for the prevention of injuries to seniors living in both community and institutional settings.[69]

SOCIAL SUPPORT

The beneficial effects of social support on health are greater for seniors with disabilities than for those without disabilities

The lack of social support among seniors is often associated with poorer health status and reduced well-being. However, people who are not as isolated, who have satisfying intimate relationships and take advantage of existing support networks can benefit from good mental and physical health. Research shows that improvements in social support have a stronger link with the likelihood of being in good or excellent health among seniors with disabilities than among those without disabilities.[66]

IMPACT OF VIOLENCE AND NEGLECT

Violence can have severe impacts on the health of people with disabilities. There is no regular national and complete data collection regarding violence against seniors with disabilities. Interested readers should consult the 2004 report for a general discussion of violence and people with disabilities.[67]

IMPACT OF INJURIES

Falls continue to be the most frequent injury among seniors with disabilities

Traumas and serious injuries are an important cause of disability among seniors. As illustrated in Figure 5.4, injuries dramatically affect the health of seniors with disabilities. The health status of seniors with disabilities who have not had serious injuries or traumas is better than those who do. For those who have been injured,

BOX 5.3 DIFFERENT FORMS OF ABUSE

Neglect is the failure of a caregiver to meet the needs of an older adult who is unable to meet those needs alone. It includes behaviours such as denial of food, water, medication, medical treatment, therapy, nursing services, health aids, clothing and visitors.

Financial abuse, also known as material or property abuse, involves the misuse of money or property. Examples include stealing money or possessions, forging a signature on pension cheques or legal documents, misusing a power of attorney, and forcing or tricking an older adult into selling or giving away his or her property.

Psychological abuse diminishes the identity, dignity and self-worth of the older person. Examples include name calling, yelling, insulting, threatening, intimidating, swearing, ignoring, isolating, excluding from meaningful events and deprivation of rights.

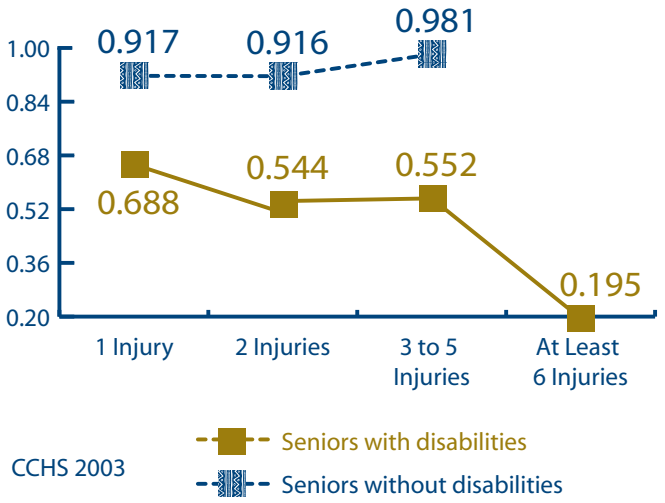
Physical abuse involves inflicting physical discomfort, pain or injury. It includes behaviours such as slapping, hitting, punching, beating, burning, sexual assault and rough handling.

Specialists in the field of abuse of older adults also recognize other forms of abuse, including medical, systemic, as well as civic and human rights abuse.[68]

their state of health further deteriorates with the number of injuries sustained. This pattern is identical to that reported in the 2004 report for all persons with disabilities. However, the corresponding levels of health for seniors are substantially lower. Injuries do not seem to have the same impact on the health status of seniors without disabilities—perhaps because they have been able to recover more quickly or the injuries did not incapacitate them in the first place. This finding needs further exploration.

In 2003, unintentional falls were the major cause of injury for 6 in 10 seniors (62%)[70]. Almost

5.4 Injuries and the Health Utility Index (HUI)



9 in 10 (85%) hospital admissions for injuries to seniors are the result of falls.

Injuries from falls are a serious health issue for seniors often resulting in long-term disability. Canada's Veteran population is proportionally older and in poorer health than the general seniors' population. It is estimated that one-third of all seniors including Veterans will suffer one or more falls this year.[71] In 2003, 7 in 10 (66%) senior women with disabilities attributed their injuries to falls compared to 5 in 10 (53%) males with disabilities of the same age.

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"Sometimes I'm sitting on the sofa and I want something from the kitchen. I have to decide if it is worth the trouble of getting up and using the walker. It is exhausting business moving this walker around. I don't go anywhere because it is quite an effort and I'm afraid of falling."[72]

IMPACT OF INDIVIDUAL BEHAVIOURAL FACTORS

BOX 5.4 ACTIVE AGEING: A POLICY FRAMEWORK

The adoption of healthy lifestyles and actively participating in one's own care are important at all stages of the life course. One of the myths of ageing is that it is too late to adopt such lifestyles in later years. On the contrary, engaging in appropriate physical activity, healthy eating, not smoking and using alcohol and medications wisely in older age can prevent disease and functional decline, extend longevity and enhance one's quality of life.

— World Health Organization. (2002) [73]

The determinants of health are now well studied and documented. It is well known that personal characteristics like age, gender, and genetics are important risk factors, but individual lifestyle factors (tobacco use, alcohol consumption, lack of exercise, and unhealthy eating) can also have an effect on health. While all of these factors are important, this report will focus only on physical activity as an example of their impact.

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"We can decide what makes us content. We can have a meaningless or meaningful life. Activity doesn't necessarily mean physical involvement. As my eyesight gets worse, I have to work at removing obstacles so that I can continue to function and do what I want to do. However, more of my activity takes place in my thought process, in my inner world. It is not only a physical thing."[74] (Don, 83)

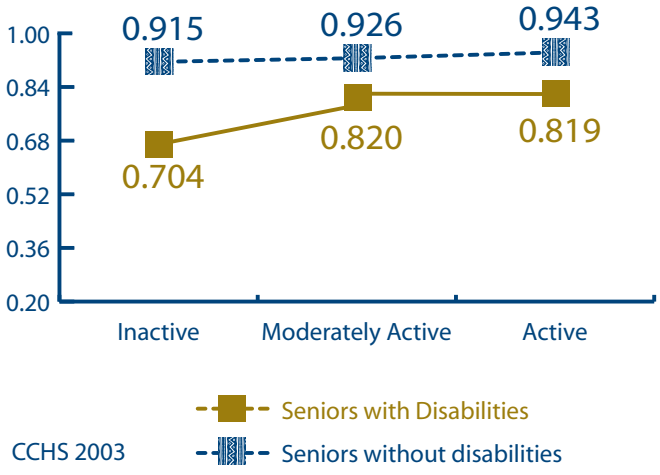
Seniors with disabilities who are even moderately physically active are more likely to be in better health

Seniors can benefit from physical activity increasing their flexibility, strength, balance, and cardiovascular fitness. Physical activity reduces the risk of strokes, coronary heart disease or diabetes. Figure 5.5 demonstrates that physical activity has a positive effect on the health of seniors with disabilities. The difference in health between people who are active (HUI = 0.819) and sedentary (HUI = 0.704) shows that seniors with disabilities who are physically active are more likely to be in better health.[75] Acknowledging that some seniors with disabilities may be unable to exercise, Figure 5.5 supports the value of seeking to engage in at least moderate physical activity. Further, the relationship between health and physical activity and the levels of health themselves are very similar to those reported for the entire population with disabilities in the 2004 report, again suggesting the importance of physical activity for seniors with disabilities.

IMPACT OF ENVIRONMENTAL FACTORS

The 2004 federal report on disability addressed the impact of environmental factors on the health of people with disabilities. In 2005, we examine the effect of these same factors on the health status of seniors with disabilities. Environmental factors can create « obstacles » that influence health and well-being as well as «facilitating » a

5.5 Physical activity and the Health Utility Index (HUI)



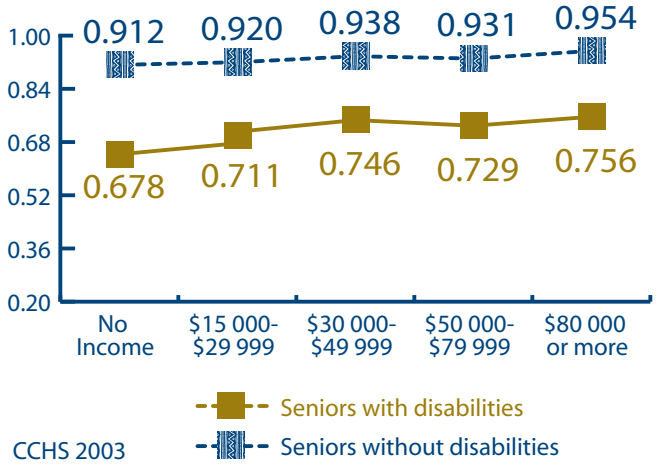
more active lifestyle. The ICF defines obstacles as factors in a person's environment that restrict their functioning and create a disability. Factors such as income, education and access to health care services can be « obstacles » or « facilitators » to the well-being of seniors with disabilities.

INCOME AND EDUCATION

The positive link between income, education and health is stronger among seniors with disabilities than for those without disabilities

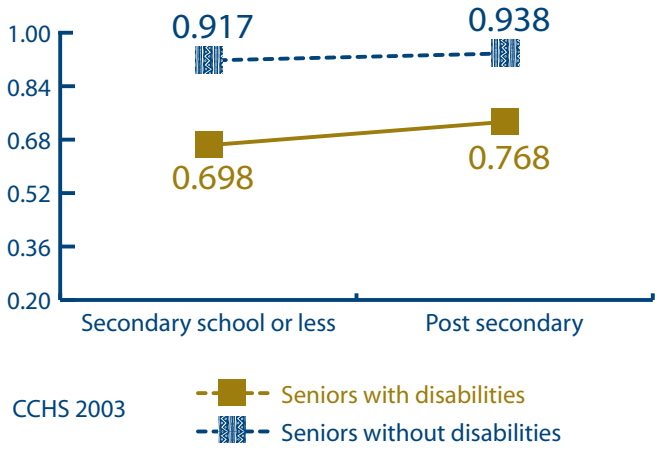
General population research shows that people who have higher incomes and higher educations are generally in better health. Figure 5.6 indicates a similar and stronger link between the household income of seniors with disabilities and their health. This positive link between income and health among seniors with disabilities is mirrored by an even stronger one observed for people with disabilities 15 years of age and over shown in the 2004 federal report on disability. Figure 5.7 shows that education also has a beneficial impact on health. Despite the beneficial effect of income and education on the health of seniors with disabilities, however, their average HUI scores never go beyond 0.8, the level at which their health status would be considered good or excellent.

5.6 Income and the Health Utility Index (HUI)



CCHS 2003

5.7 Education and the Health Utility Index (HUI)



CCHS 2003

ACCESS TO HEALTH CARE

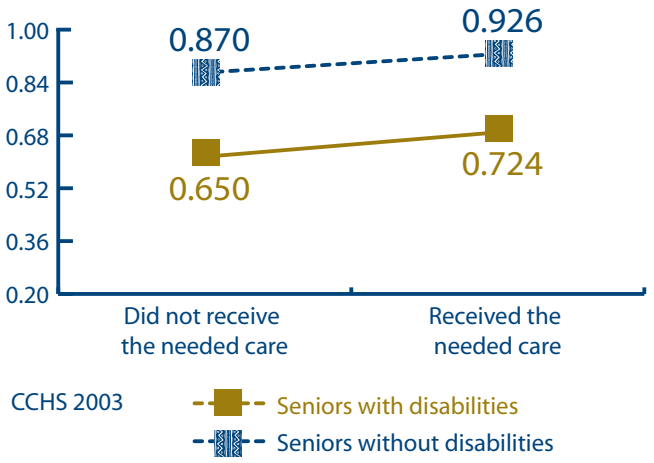
Failure to receive needed health care has a greater negative impact on the health of seniors with disabilities than on seniors without disabilities

Seniors are more likely to consult a doctor or another health professional than most other adults. In addition to consulting for health problems that may affect the majority of the population, seniors also often call upon health professionals for conditions related to aging. Having health care needs met is important to the health of seniors with disabilities.

Figure 5.8 shows that failure to receive needed care has a greater impact on seniors with disabilities than on those without disabilities and is also more significant than the impact observed for the general population of people with disabilities (see the 2004 report). However, the HUI of those receiving needed health care still remains under 0.8, the level customarily signalling very good or excellent health.

HEALTH-RELATED QUALITY OF LIFE

5.8 Access to health care and the Health Utility Index (HUI)



There is no consensus on a single meaning for the concept of "quality of life". However, the WHO active aging framework indicates that it is closely related to the idea of being able to fully participate in daily life. The concept of quality of life across all areas of life can be distinguished from quality of life linked to health. "Generally, the notion of [health-related] quality of life is used to designate the echoes of pathology on the physical, psychological and social life of a patient."[76]

The Short Form 36 or SF-36 is the most commonly used instrument in the world to measure health-related quality of life. The SF-36 contains 36 questions and is an abbreviated version of the Medical Outcomes Study (MOS) questionnaire designed to be used in population surveys and health policy evaluation studies.[77] The SF-36 includes scales with multiple items aimed at evaluating eight dimensions of health status as shown in Table 5.1 below.

Health-related quality of life is similar to the autonomy and independence goals of active aging. A higher level of quality of life, as measured by the SF-36, reflects the capacity to function autonomously, to maintain a level of physical and mental health and participate in social life.

Figure 5.9 presents the different dimensions of SF-36 with scores for seniors with disabilities.

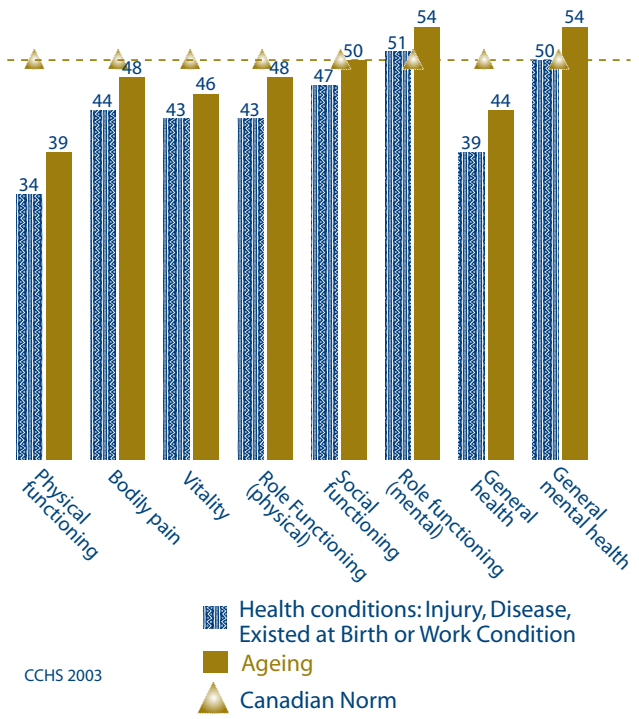
TABLE 5.1: Dimensions of the SF-36

NAME OF SCALE	CONTENT
Physical functioning	Measures activity limitations such as walking, climbing stairs, bending over, lift objects and physical effort.
Role limitations due to physical health problems	Measures the intensity of difficulty and discomfort in daily activities due to physical health problems.
Bodily pain	Measures the intensity of pain.
General health perception	Self-evaluation of health in general and resistance to illness.
Vitality (Energy and fatigue)	Measures vitality, energy and fatigue.
Social functioning	Measures social activity limitations due to mental and physical problems.
General Mental health	Measures mental health: anxiety, depression, emotion.
Role limitations due to mental or emotional problems	Measures the intensity of difficulty and discomfort in daily activities due to mental health problems

The scores for seniors who say the cause of their disability is due to aging are contrasted with those who associate their condition with injuries, disease or problems at birth. For purposes of comparison, all scores have been standardized against a score of 50 representing the Canadian population norm.

The Figure shows that, aside from average scores for overall mental health, all scores are below the Canadian norm. The more interesting result, however, is that scores for those who consider their condition to be caused by normal aging

5.9 Health-related quality of life (SF-36) by the cause of health conditions for seniors with disabilities (%)



are uniformly higher than for those who believe their condition has other causes. In other words, "normal aging" even for people with disabilities has less effect on health-related quality of life than does aging accompanied by injuries or disease. As shown in the Figure, all but two of the scores for seniors with disabilities who see their condition as the result of normal aging are close to or above the Canadian population norm.

CONCLUSION

With appropriate supports, seniors with disabilities can have quality of life similar to that of the rest of the seniors population

Whether based on the self-rated health index or the more sophisticated McMaster University Health Utility Index, seniors with disabilities report worse health than do their peers without disabilities. This pattern is similar to that reported in last year's report.

More importantly, however, this chapter has shown that a wide range of factors identified in health promotion and population health approaches have similar relationships to health as they do in the population without disabilities. Factors such as increased social support, physical activity, injury prevention, adequate income and appropriate health care have beneficial effects on health sometimes stronger than those observed among seniors without disabilities and (referring to results reported in the 2004 report) younger people with disabilities.

While the overall health of seniors with disabilities is not reported to be as good as the health of seniors without disabilities, the evidence presented here suggests that disability does not mean lost quality of life. Seniors with disabilities can have good quality of life if the impact of disabling conditions is met by appropriate supports.

GOVERNMENT ACTION ON PROMOTING THE HEALTH OF SENIORS WITH DISABILITIES

HEALTH CANADA AND THE PUBLIC HEALTH AGENCY OF CANADA

- Integrated Pan-Canadian Healthy Living Strategy* (intersectoral)
- Integrated Strategy on Healthy Living and Chronic Disease* (federal)
- Family Violence Initiative including the National Clearinghouse on Family Violence*
- The Falls Prevention Initiative (with Veterans Affairs)*
- Population Health Fund*
- Non-insured Health Benefits Program*

VETERANS AFFAIRS CANADA

- Veterans Treatment Benefits Program*
- Veterans Independence Program
- Safely Home-Alzheimer Wandering Registry
- Ste-Anne's Hospital

* These programs are only partially targeted to people with disabilities. See the discussion of "partially- targeted measures" in Chapter 9.

CHAPTER 6
INCOME

HIGHLIGHTS

- Senior women with disabilities are more likely to have lower household income than other seniors and other age groups
- In 2003, senior women with disabilities had significantly lower after-tax income ($37,637) than senior men with disabilities ($43,524)—and $3,000 less than corresponding incomes for senior women without disabilities
- 3 in 10 seniors with disabilities living alone in rented accommodation have low incomes
- 7 in 10 seniors with disabilities rely on government transfers such as the Canada Pension Plan as their major source of income
- Seniors with disability have twice the chance of experiencing food insecurity as seniors without disabilities
- The median net worth of seniors without disabilities who provide for families is almost 2.5 times higher than those who are unattached; the difference for seniors with disabilities is even greater

WE ALL need money to meet our basic living needs, to participate in activities and realize our full potential. People with disabilities often face particular challenges in employment, generally have lower levels of education, and have additional costs related to their disability. For seniors with long-term disabilities, securing an adequate income can be an ongoing struggle if they were unable to amass pension or retirement savings during their working years. Disabilities acquired after retirement may not affect income levels, but they can generate new disability-related expenses.

This chapter presents five indicators measuring how these seniors—both seniors experiencing disability as they age and those who are aging with a long-term disability— have their income needs met.

INDICATORS

BOX 6.1 INCOME INDICATORS

- Household income
- Persons living in low-income households
- Major source of personal income
- Food security
- Net worth

HOUSEHOLD INCOME

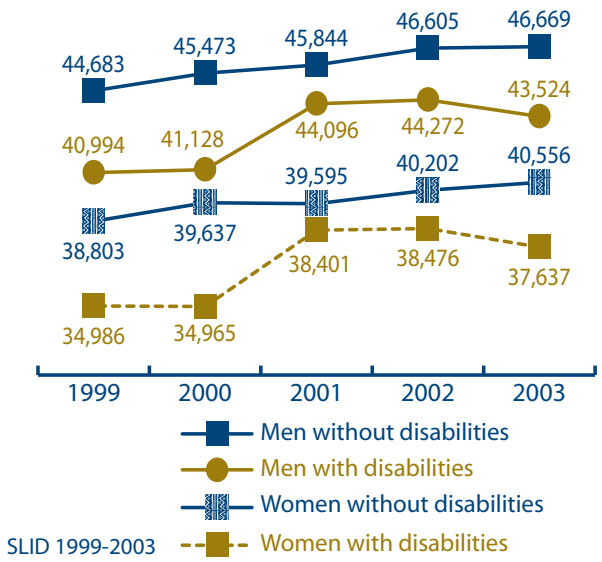
Senior women with disabilities are more likely to have lower household income than other seniors and other age groups

Seniors, regardless of disability status, have lower household income on average than other adult age groups. However, it is difficult to compare household income of senior households with that of younger cohorts because seniors—whether living with a disability or not—have lower expenses. They do not generally support children, have employment-related expenses nor contribute to pension plans, and most pay lower taxes.[78]

However, seniors with disabilities in general are more likely to live on their own, increasing the odds of living with a lower household income. Senior women with disabilities in particular, many of whom outlive their partners, are even more likely to live alone—an arrangement that impacts negatively on their income levels.

Figure 6.1 presents the differences in average annual incomes between seniors with and without disabilities.[79] The figure shows that women with and without disabilities have lower

6.1 Average after-tax household income for seniors ($)



household incomes than men. The primary reasons for this are that senior women are more likely to live alone and women are also less likely to have private pension income to supplement their government benefits. All household income numbers have risen progressively, but the gaps observed in the 1999 data remain similar in 2003. In 2003, the average household income for senior men with disabilities was $43,524, and $37,637 for senior women with disabilities. These figures are approximately $3,000 less than the corresponding household incomes for senior men and women without disabilities.

In 2003, senior women with disabilities had significantly lower after-tax income ($37,637) than senior men ($43,524)—and $3,000 less than corresponding incomes for senior women without disabilities

PERSONS LIVING IN LOW-INCOME HOUSEHOLDS

3 in 10 seniors with disabilities living alone in rented accommodation have low incomes

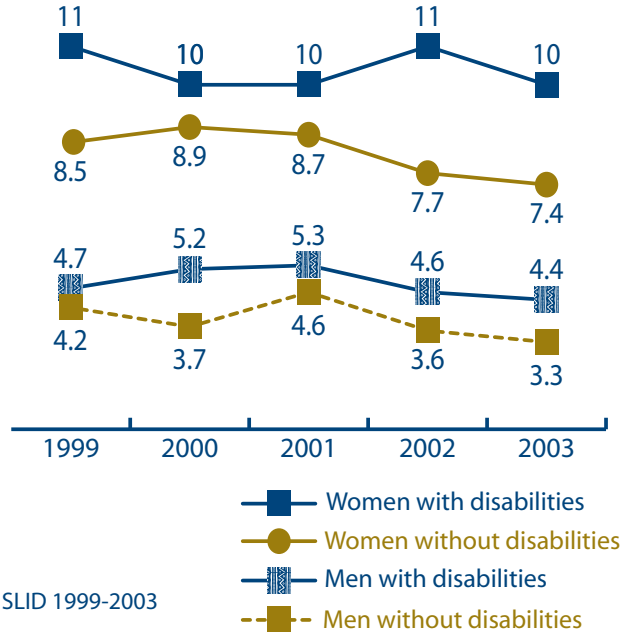
Rates of low income among seniors have remained relatively stable over the past five years with a trend towards slightly lower rates of people living in low-income households. The gaps based on gender and disability have remained similar over the five-year period shown.

Statistics Canada's Low Income Cut-Off (LICO) is a relative measure based on the percent of income spent on basic needs by an average family. The after-tax LICO is set according to the proportion of annual after-tax income (total income including government transfers after the deduction of income taxes) spent on basic needs (food, clothing and shelter). A household that spends 20% more on basic needs than the average family is considered to be living below the low-income cut-off. The LICO is adjusted for location and family size.

Figure 6.2[80] shows that among seniors in 2003, women with disabilities were the most likely to be living in a low-income household (10%) compared to women without disabilities (7.4%), men with disabilities (4.4%) or men without disabilities (3.3%). As reported in 2004, working-age people with disabilities are significantly more likely to live in low-income households. This is because seniors with disabilities benefit from the income security system that Canada has put in place for all seniors.

The rates shown in Figure 6.2 are aggregate rates combining seniors living alone and those

6.2 Seniors living below the after-tax low income cut off (%)



living with a spouse or other family members. Both men and women living alone are much more likely to have low incomes, however. In 2002 for example, 20% of senior women and 18% of senior men with disabilities who lived alone had incomes below the LICO. Among seniors with disabilities living alone and who are renting their dwelling, rates of low income are even higher—27% for women and men. Living alone also coincides with higher rates of low income among seniors without disabilities (women 17%, men 15%)

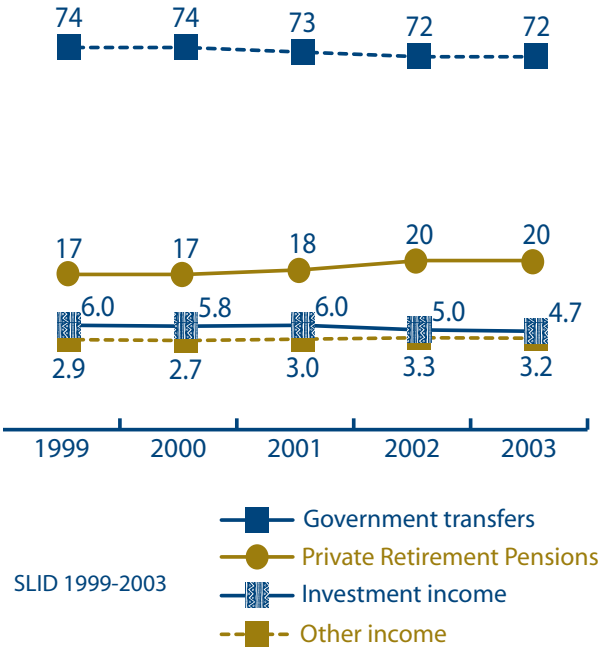
MAJOR SOURCE OF PERSONAL INCOME

7 in 10 seniors with disabilities rely on government transfers such as the Canada Pension Plan as their major source of income

Income may come from a variety of sources, but a history of full-time paid employment is the greatest determinant of higher personal income even after retirement. Seniors without disabilities during their working years are more likely to have been in the workforce most of their working-age years. Seniors with long-term disabilities may not have had straightforward patterns of employment, with direct implications for income available for their senior years.

Income for the vast majority of seniors with disabilities comes from sources other than earnings including the Canada Pension Plan or private retirement pension plans. Figure 6.3 shows that in 2003, 72% of seniors with disabilities relied on government transfers as their major source of income and 20% counted on private retirement pensions as their primary source of income. These figures compare to 63% and 26% of seniors without disabilities. Only a small minority of seniors with disabilities have investment income as their primary source of income. The figure also shows a small shift away from government transfers and towards private pension plans between 1999 and 2003.

6.3 Major source of personal income for seniors with disabilities (%)



SLID 1999-2003

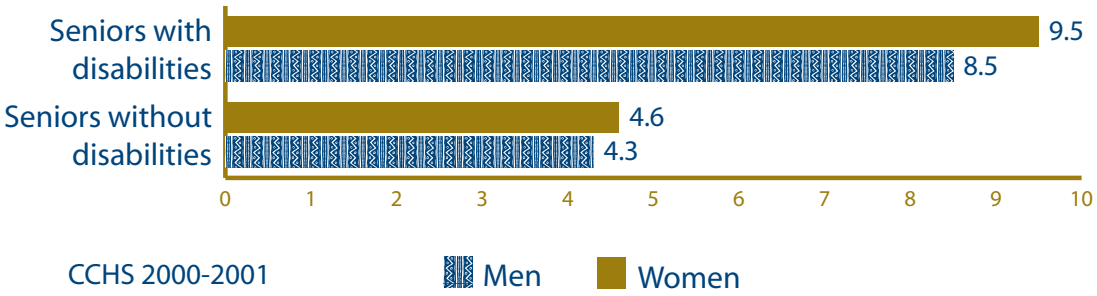
FOOD SECURITY

Seniors with disability have twice the chance of experiencing food insecurity as seniors without disabilities

Examining whether people have enough money to sustain the most basic of needs—eating sufficient, safe, healthy and nutritious foods—provides an important measure of the adequacy of income. The CCHS provides an analysis based on whether respondents with and without disabilities have experienced food insecurity at least once in the course of a year. The survey defines food insecurity as worrying about not having enough to eat or not having the desired quality or variety of food due to lack of money. Figure 6.4 shows that seniors with disabilities have twice the chance of experiencing this type of insecurity as seniors without disabilities. Although senior women are slightly more likely to experience food insecurity, there is little distinction to be made based on gender.

Food insecurity represents a sign of personal and household insecurity, and is closely linked to income insecurity. However, food insecurity

6.4 Food insecurity among seniors (%)



is a complex issue not solely related to income. People can experience this insecurity because they need help with the purchase of food. Some key barriers to food acquisition are mobility or agility issues, fear of going out in bad weather, intellectual disabilities, transportation costs or accessibility, limited choice of shopping venues without transportation, inability to buy larger bulk packages or to store food. Some of these factors may require more frequent shopping trips with small packages, which may result in higher food-related expenditures and a higher risk of food insecurity.

Food insecurity among seniors with disabilities also refers to the difficulties of preparing and eating available food. PALS found, for example, that about 4% of seniors with disabilities have unmet needs for assistance with meal preparation.

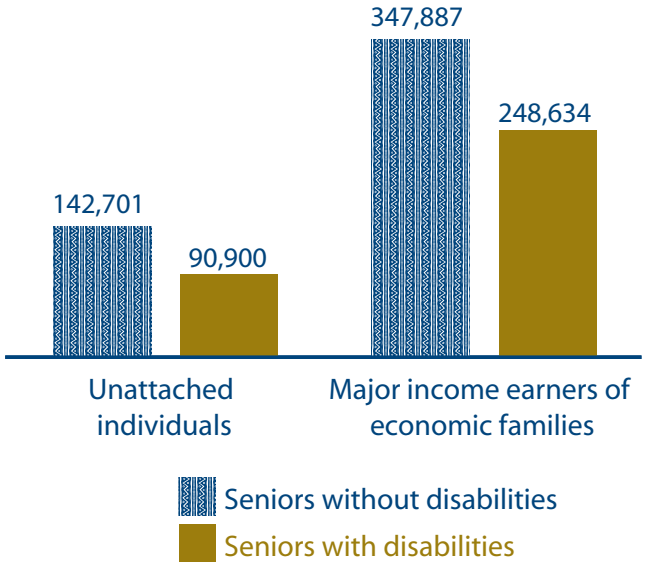
NET WORTH

Net worth is the difference between your assets—the value of what you own (home, car, objects of value, balance in savings and checking accounts, saving bonds, retirement savings, stocks, mutual funds, life insurance, etc.) and your debts—the value of what you owe (mortgage, car payments, loans and debts). Knowing the difference between what you own and what you owe is a key to understanding income adequacy and the well-being that may come with it.

While seniors tend to have a lower income than younger people, they also tend to have higher net worth. By their older years, seniors have accumulated assets over many years and tend to have less debt. Both seniors with and without disabilities have a median net worth that is much higher than younger people.

The median net worth of seniors without disabilities who provide for families is almost 2.5 times higher than those who are unattached; the difference for seniors with disabilities is even greater

6.5 Median net worth of seniors ($)



Survey of Financial Security 1999

As shown in Figure 6.5, there are major differences in the median net worth of seniors who are unattached individuals and of seniors who are major income earners of families either with or without a disability. For seniors without disabilities, the median net worth of those who

provide for families ($347,887) is almost 2.5 times higher than those who are unattached ($142,701). In the case of seniors with disabilities, the difference is even greater: seniors with disabilities who are unattached have a median net worth of $90,900 compared to $248,634 for seniors with disabilities who are major income earners of families. For those in long-term relationships, this difference may result from lengthy periods of combining expenses, income and accumulation of assets.

In comparing these results to those reported for the overall population in the 2004 report, the net worth of seniors with disabilities is substantially higher than that of their younger counterparts. Younger people with disabilities have generally had little opportunity to amass assets, whereas seniors, especially those who have aged into disability at older ages, have done so for many decades.

CONCLUSION

Canada's income security system for seniors has significantly reduced the occurrence of low-income among seniors in recent decades. Because seniors with disabilities benefit from this system, they are less likely to live in low-income households than are working-age people with disabilities. However, low income is an issue for some seniors, especially those who live alone. Once again, it is older women with disabilities, who often outlive their partners, who are most likely to live alone and have low incomes.

In general, seniors with disabilities live in households with incomes lower than those of seniors without disabilities. They are also less likely to have significant incomes from private pensions or personal retirement savings and fewer assets. These differences seem likely to derive from the experience of those acquiring their disabilities well before the age of 65. However, additional research is needed to fully understand this pattern.

GOVERNMENT ACTION ADDRESSING INCOME NEEDS OF SENIORS WITH DISABILITIES

FINANCE CANADA AND THE CANADA REVENUE AGENCY

- Tax measures for people with disabilities (e.g. Disability Tax Credit)

SOCIAL DEVELOPMENT CANADA

- Canada Pension Plan*
- Old Age Security*
- Guaranteed Income Supplement*

VETERANS AFFAIRS CANADA

- Veterans Disability Pension**
- War Veterans Allowance

* These programs are only partially targeted to people with disabilities. See the discussion of "partially- targeted measures" in Chapter 9.

** Veterans disability pensions provide compensation for disabilities suffered as a result of service and are not considered as income for tax purposes.

CHAPTER 7
FIRST NATIONS, MÉTIS AND INUIT ELDERS WITH DISABILITIES

HIGHLIGHTS

- Over 976,000 people (3.3% of the total Canadian population) report Aboriginal identity
- While relatively few in number, elders 65 years of age and over are the fastest growing age group overall among Aboriginal people
- According to the 2001 Census, about 60% of First Nations elders, 64% of Métis, 54% of Inuit and 50% of non-Aboriginal seniors have disabilities
- Among elders living on reserve, 42% indicated that their homes require major repairs
- Among elders with disabilities, 17% rate their health as very good or excellent compared to 25% of non-Aboriginal seniors
- 1 in 4 Aboriginal women age 65 and over have diabetes, compared to 1 in 10 for the same age group of non-Aboriginal women
- Aboriginal elders with disabilities often have to move from rural, remote and isolated communities to urban centres to get services
- Language and cultural barriers, geographic isolation and transportation needs and location of service personnel may impede service delivery to Aboriginal elders
- 4 in 10 (38%) First Nations elders with disabilities age 55 and over living on reserve have household incomes below $20,000

DEFINING THE POPULATION

In earlier chapters, this report has focused on Canadian seniors with disabilities along with the implications of population aging for disability policy. However, the term `seniors' does not reflect the traditional and distinctive role that older people-elders-play in Aboriginal communities.

Historically, elders have played an important and well-respected role in the cultural and community life of many Aboriginal communities. This reality influences the roles and acceptance of Aboriginal elders with disabilities. The diversity within Aboriginal communities does not allow for a single definition of elder. However, this chapter will generally use the term elder to refer to Aboriginal people who are 55 years or older.

Understanding the situation of Aboriginal elders with disabilities is difficult. There is a lack of statistical information and sparse research. Four principal statistical data sources, all of which have limited disability data have been used for this chapter: the 2001 Census, the 2001 Aboriginal Peoples Survey (APS) both conducted by Statistics Canada, the 1996-1997 First Nations and Inuit Regional Health Survey (FNIRHS) and the 2002-2003 First Nations Longitudinal Regional Health Survey (RHS). (See Appendix D for further details about these surveys.) The information in this chapter will assist in developing a stronger base of knowledge for both Aboriginal and non-Aboriginal policy makers.

POPULATION PROFILE

Over 976,000 people (3.3% of the total Canadian population) report Aboriginal identity

Just over 1.3 million people (4.4% of the total Canadian population) report Aboriginal ancestry or origin[81] and over 976,000 people (3.3% of the Canadian population) report Aboriginal identity in one or more Aboriginal groups. First Nations

are the largest Aboriginal group, followed by Métis and Inuit. Altogether, Aboriginal people in Canada include more than 50 distinct cultural groups.[82]

First Nations, Métis and Inuit live in many different types of communities and this has a direct impact on health status, health and social services delivery, support needs and community capacity. The highest concentrations of Aboriginal population are in the North and the prairies. In contrast, the largest provincial population of Aboriginal people (188,315) lives in Ontario, where it accounts for less than 2% of the total population.

Over the past 30 years the Aboriginal population in Canada has become increasingly urbanized, with almost half of Canada's Aboriginal people living in urban areas in 2001. This varies by cultural group, with 68% of the Métis population living in urban areas while 14% of Inuit live in southern urban areas. Aboriginal people are also more mobile than the general Canadian population. In the 12 months before the Census, 22% of Aboriginal people had moved compared to 14% of the non-Aboriginal population. Rural non-reserve areas and non-metropolitan urban areas had a net loss of Aboriginal people, while larger urban centers and reserves had a net gain.

While the Aboriginal population in 2001 was much younger than the non-Aboriginal population, demographic trends indicate that the number of Aboriginal seniors is rising, albeit more slowly than in the total Canadian population. This is in large part due to gradual improvement in life expectancy and a declining birth rate among Aboriginal people. Between 1975 and 2000, the life expectancy of Aboriginal men increased from 59.2 to 68.9 years and that of women increased from 65.9 to 76.9 years for women.[83] Aboriginal fertility has declined from about four times the overall Canadian rate in the 1960s to one-and-a-half times today.

ELDER

"Elder" is a title given to Aboriginal individuals in recognition of their knowledge, wisdom, experience and/or expertise. Elders provide guidance and often enhance the quality of community life through counselling and other activities. Elders often have special skills or abilities, including knowledge of ceremonies and traditional ways and the ability to tell the stories and history of their people.

Elders are generally but not always the older members of the community. Thus, the terms 'Elder' and 'senior' do not always mean the same thing. . . . 'Elder' is capitalized when used to indicate honour or a title. It is not capitalized when it is used to mean senior.

Reaching Out: A Guide to Communicating with Aboriginal Seniors. Division of Aging and Seniors. Health Canada (1998).

While relatively few in number, elders 65 years of age and over are the fastest growing age group overall among Aboriginal people

In 2001, the percentage of Aboriginal elders age 65 and over only accounted for about 4% of the Aboriginal population compared to the general population where seniors accounted for 13%.[84] While relatively few in number, elders 65 years of age and over are the fastest growing age group overall among Aboriginal people. Between 1996 and 2001, North American Indian elders increased by 31% (to 24,170), Métis elders remained nearly constant in number (12,520) and Inuit elders increased by 38% (to 1,405). As life expectancies continue to improve, continued increases are expected in the number of elders.[85] However, despite improved life expectancies, there are sustained health inequities between Aboriginal and non-Aboriginal Canadians.

According to the Health Council of Canada annual report released in 2005: The health of

TABLE 7.1 Aboriginal People in Canada (2001 Census)			
GROUP	**NUMBER**	**% OF ABORIGINAL IDENTITY POPULATION**	**% OF CANADIAN POPULATION**
Total Reporting Aboriginal identity	976,305	100	3.3
North American Indian identity	608,850	62	2.0
Métis identity	292,310	30	1.0
Inuit identity	45,070	5	0.2
Multiple identities and other responses	30,075	3	0.1

First Nations, Inuit and Métis people is worse than that of the general Canadian population on virtually every measure of health and every health condition, including: shorter life spans, higher rates of suicide and infant mortality, and higher rates of diabetes.[86] The growth of the population of elders with its attendant higher rates of chronic health problems may create dramatic increases in the demand for resources at the community level.

■ PROFILE OF ABORIGINAL ELDERS WITH DISABILITIES

According to the 2001 Census, about 60% of First Nations elders, 64% of Métis, 54% of Inuit and 50% of non-Aboriginal seniors have disabilities

Disability is a critical issue for First Nations, Métis and Inuit people. According to the 2001

TABLE 7.2 Aboriginal people with disabilities by group							
	ALL AGES	**15-64**			**65 AND OVER**		
	Total population	Total population	Pop. with disabilities	% with disabilities	Total population	Pop. with disabilities	% with disabilities
Canadian Population	29,639,035	20,276,510	2,629,355	13.0%	3,624,485	1,801,105	49.7%
All Aboriginal identity	976,305	596,720	113,250	19.0%	38,360	23,500	61.3%
North American Indian identity	608,850	371,155	66,765	18.0%	24,170	14,580	60.3%
Métis identity	292,310	195,095	41,465	21.3%	12,520	7,980	63.7%
Inuit identity	45,070	26,200	3,685	14.1%	1,405	765	54.4%
Multiple identities	6,660	4,270	1,235	28.9%	265	175	66.0%

Census, 60.3% of First Nations, 63.7%, of Métis and 54.4% of Inuit in the group aged 65 and over report having a disability compared to 50.2% for the total Canadian population.[87] Other surveys have also reported that Aboriginal populations experience high rates of disabilities. Recently, the 2002 RHS found that 23% of First Nations people aged 18 and over have a disability compared to 50% of First Nations elders aged 60 and over.[88] The 2001 APS found that 70% of Aboriginal people of age 65 and over have a disability—a level even higher than that reported in the Census. According to the APS, First Nations people over age 65 living on reserves have the highest rate of disability among all Aboriginal groups (75%).

Table 7.2: Total elders in the population with disabilities for First Nations, Métis and Inuit (Census 2001) in comparison with the total Canadian population (excluding collective dwellings)

Aboriginal women elders have one of the highest rates of disabilities of all groups in the country. Data from the 2001 APS show that 72% of Aboriginal women age 65 and over have disabilities compared to 68% of men. First Nations and Inuit women age 65 and over are more likely to have disabilities than men, but among the Métis, the percentages are nearly equal (men 67%, women 68%).

INDICATORS

The remainder of this chapter will follow the framework of disability supports, health and income used in the preceding chapters of this report. This approach will help facilitate comparison of issues facing Aboriginal elders with disabilities to those facing other seniors with disabilities in Canada.

The issues faced by Aboriginal elders with disabilities are often affected by the distinct social, economic, cultural, political and environmental contexts in which they live. Further, these contexts vary between and among cultural groups for First Nations, Métis and Inuit people. To provide two examples:

BOX 7.1 INDICATORS FOR ABORIGINAL ELDERS

DISABILITY SUPPORTS

- Home modifications and housing

HEALTH AND WELL-BEING

- Self-reported health
- Impact of chronic conditions
- Impact of environmental factors

INCOME

- Household income
- Persons living in low-income households

First Nations, Métis and Inuit have developed approaches to disability based on principles of caring, respect, dignity and acceptance of diversity. Family and community are very important in Aboriginal society and communities have traditionally held their aging members in highest esteem, turning to them for advice, teaching and guidance in the raising of children and the transmission of language, cultural practices, and traditional knowledge. Not only are elders in Aboriginal communities responsible for the transmission of ancestral wisdom and spiritual guidance but they also play active roles in the everyday life of the community.

From another perspective, significant numbers of Aboriginal people live in small, remote Northern communities often lacking in basic infrastructure that is taken for granted elsewhere. Often, travel in and out of these communities is difficult, expensive and occasionally impossible. Small aircraft and boats are often not properly equipped to transport people with disabilities. These factors create a particular challenge in meeting health care and support needs for this highly-dispersed population.

To incorporate the full range of social, economic, cultural and political differences between Aboriginal and non-Aboriginal seniors with disabilities is beyond the scope of the brief overview provided here.

As already mentioned, statistical data on Aboriginal elders with disabilities are not yet well developed. Data from the 2001 APS highlight some of the indicators in the framework while the 2002 RHS allows for some discussion as they apply to First Nations communities. Other sources provide information to discuss other indicators in a more general way. Box 7.1 summarizes the indicators to be presented in some detail.

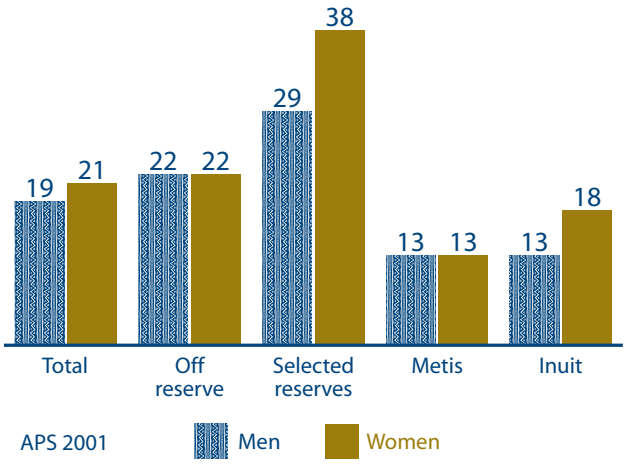
■ DISABILITY SUPPORTS

First Nations, Inuit, and Métis elders with disabilities need the same forms of support for their disabilities as other Canadians. They need adequate income; social, community and family support; learning opportunities; access to health and social services; a physical environment that can accommodate their needs; and a system that is barrier free and culturally appropriate.

Beyond factors affecting all seniors, there are several overriding issues that influence their ability to get the care and support they need. First is the complex jurisdictional arrangement governing provision of supports, services, and health care. Second is the need for more culturally-appropriate services and Aboriginal -designed and -controlled programs, supports, and services. Also very important, is the continuing low income levels of many Aboriginal people. While there are differences among the three Aboriginal groups, there are common issues that apply to all three groups.

Like other seniors with disabilities, First Nations, Inuit, and Métis elders with disabilities need personal aids and devices, assistance with everyday living, physically accessible buildings, transportation, medical and community-based supports, family and caregiver support, and housing that meets individual disability needs.

7.1 Aboriginal elders (55 and over) with disabilities who need special features at home to assist with health conditions (%)



HOME MODIFICATIONS AND HOUSING

Housing in many Aboriginal communities is less adequate than in non-Aboriginal communities, creating additional barriers for Aboriginal elders with disabilities.[89] Studies have shown that Aboriginal housing is in great part inadequate, substandard, ill-suited to environmental and cultural concerns, overcrowded, and lacking in amenities, such as running and potable water and basic plumbing. The situation is not much improved among Aboriginal people living in urban settings. According to the 1998 report *Gathering Strength: Canada's Aboriginal Action Plan,* one-half of all Aboriginal people in Canada live in urban centres, with many struggling to find affordable, accessible housing that will provide not only shelter but a sense of self-worth and independence.[90]

Among elders with disabilities living on reserve, 42% indicated that their homes require major repairs

Crowded living conditions are an issue for 17% of non-reserve Aboriginal people and 53% of Inuit people, compared with 7% of all Canadians. According to the 2001 APS, approximately 21% of Aboriginal elders with disabilities age 55 and over reported that their homes required major repairs compared to 19% of their peers without disabilities. The situation was most severe among elders with disabilities living on reserve, where 42% indicated that their

homes require major repairs followed by 27% of Inuit elders with disabilities.

The cost of housing in northern communities is significantly higher—up to three times the cost for similar accommodation elsewhere in the country.

In addition to the general lack of acceptable housing for many Aboriginal people, a significant percentage of Aboriginal elders that have special housing needs related to their disability are not having their needs met. Approximately 20% or 9,400 Aboriginal elders with disabilities age 55 and over indicated that "they or someone in their household needed special features to assist with health conditions or health problems." In total, 36% of these elders with disabilities reported they did not have what they needed.

Figure 7.1 shows that First Nations elders with disabilities are more likely to report a need for special features than Inuit or Métis elders. First Nations women and men living on reserve are more than twice as likely to report a need than are Inuit or Métis elders. They are also more likely to report a need than are First Nations elders living off reserve.[91]

■ HEALTH AND WELL-BEING

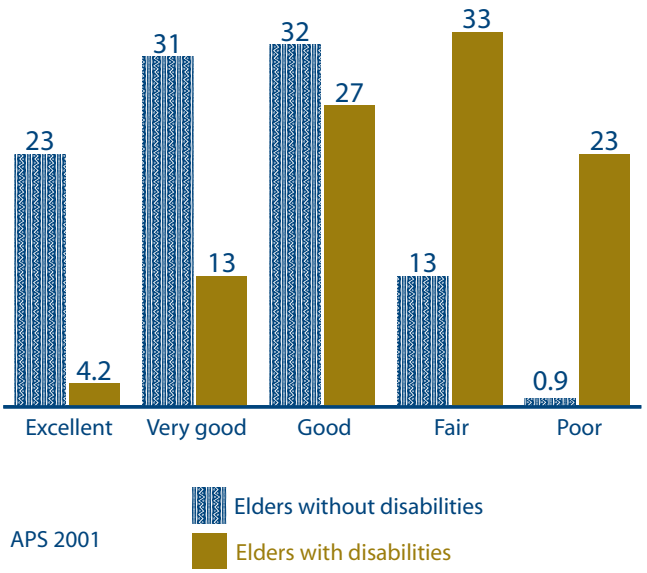
SELF-RATED HEALTH

Among elders with disabilities, 17% rate their health as very good or excellent compared to 25% of non-Aboriginal seniors

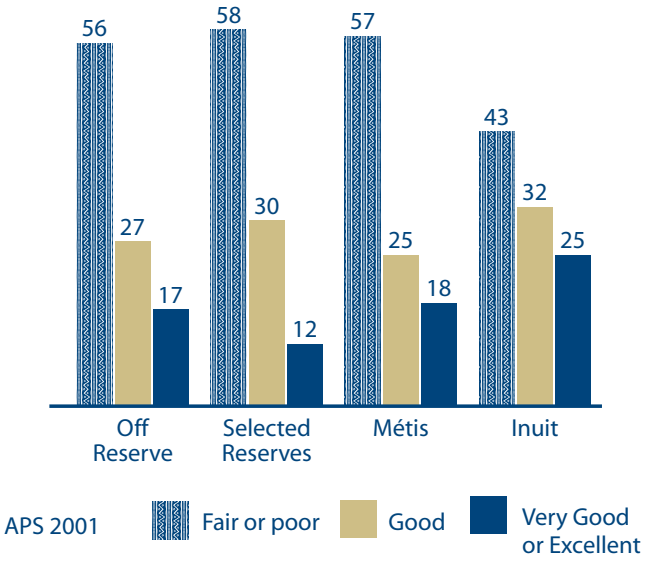
As for all seniors, health is key to allowing First Nations, Métis and Inuit elders with disabilities to contribute more fully to their families and communities. As shown in Figure 7.2, 56% of Aboriginal people age 55 and over with disabilities rate their health as fair or poor, compared to only 14% of their peers without disabilities. Some 17% of elders of age 55 and over with disabilities rate their health as very good or excellent in contrast to 54% of elders without disabilities. We can also compare these results to those reported in Chapter 5 for non-Aboriginal seniors, where 35% of seniors with disabilities rated their health as fair or poor and 25% assessed it as excellent or very good.

As shown in Figure 7.3, First Nations elders with disabilities off reserve, on reserve and Métis assess their overall health similarly. However, Inuit elders with disabilities seem to rate their health somewhat better than the other groups. The reason for this is not clear. With respect to First Nations elders with disabilities

7.2 Self-reported health of Aboriginal elders, 55 and over (%)



7.3 Self-rated health for Aboriginal elders with disabilities by group (%)



living on reserves, the 2002 RHS found similar results, reporting that 65% rated their health as fair or poor.[92]

CHRONIC CONDITIONS

1 in 4 Aboriginal women age 65 and over have diabetes, compared to 1 in 10 for the same age group of non-Aboriginal women

Many studies have found sustained health inequities and issues around systemic access to appropriate care for Aboriginal Canadians. As well, according to Health Canada, there is a prevalence of chronic disease in Aboriginal communities such as diabetes, cancer, heart disease, arthritis and high blood pressure.[93] For example, 1 in 4 Aboriginal women age 65 and over have diabetes, compared to 1 in 10 for the same age group of non-Aboriginal women.[94] These conditions are strong predictors of severe disabilities in older people if left unaddressed. Cases of chronic diseases appear to be increasing among Aboriginal people. Since these conditions can cause physical limitations of elders this is a key issue to be addressed in future planning and policy.

Diabetes provides an example of the link between chronic diseases and activity limiting conditions associated with disabilities. People with diabetes have a substantially increased risk of developing cardiovascular disease or stroke and have a higher prevalence of hypertension. They also have a 15 times greater risk of requiring lower extremity amputation than those without diabetes and higher rates of kidney disease requiring dialysis, as well as retinopathy, which is the leading cause of adult-onset blindness in North American adults.

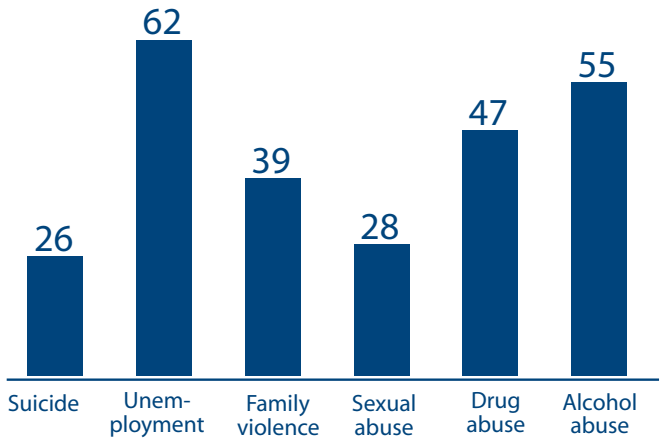
ENVIRONMENTAL FACTORS

Aboriginal people consider health as a dynamic process involving the harmony of the person with their physical, social and spiritual environments. This approach parallels ideas introduced in chapter 5. That chapter links the health of seniors with disabilities to a number of factors including chronic conditions, injuries, violence, social support, physical activity, income, education, and access to health care.

The APS permits a limited exploration of the presence of some of these factors in Aboriginal communities. The 2001 APS asked respondents whether suicide, unemployment, family violence, sexual abuse, drug and alcohol abuse were problems in their community or neighbourhood. Figure 7.4 shows that significant numbers of elders with disabilities believe these problems are present in their communities.

In each case, First Nations, Métis and Inuit elders most frequently identified alcohol abuse, drug abuse and unemployment as social problems affecting their communities. There were no systematic differences in perceptions between elders with and without disabilities. It seems likely that these problems contribute both to the high rates of disability in Aboriginal groups and to the health problems experienced by those with and without disabilities. They may also be seen both as a cause and consequence of community and social environments where disabilities are not adequately dealt with by service providers or the community itself.

7.4 Problems in the community as perceived by elders with disabilities (%)



ACCESS TO HEALTH CARE AND SERVICES

Aboriginal elders with disabilities often have to move from rural, remote and isolated communities to urban centres to get services

Various studies have documented gaps in support and services for Aboriginal health, which affect standards of care for Aboriginal elders with disabilities. The availability of support, treatment and rehabilitation services, within or close to the community is essential to meeting the needs of Aboriginal people with disabilities. For those who live in rural, isolated, or remote communities, contact with outside disability services or agencies is often limited or non-existent. Access to supports can also be difficult because of poor road conditions, lack of roads, transportation services.[95] These factors force many Aboriginal elders with disabilities to move from rural, isolated communities to urban centres to access services.[96] Moving an Aboriginal elder with a disability to a mainstream environment for care can interrupt that person's strong ties to the land, their family and support they receive from their community.

In addition, the lack of health service models that incorporate culturally sensitive approaches to health care as well as varying degrees of awareness and sensitivity to First Nations, Inuit and Métis disability issues by services providers can result in "culture shock" for Aboriginal seniors with disabilities. This may have a significant impact on that individual's healing process and overall health outcomes. If non-Aboriginal health-care providers are aware of and versed in Aboriginal social and cultural values and practices, Aboriginal elders with disabilities are more likely to successfully access mainstream services and experience better treatment and healing outcomes.

Language and cultural barriers, geographic isolation and transportation needs and the location of service personnel may impede service delivery to Aboriginal elders with disabilities.

Health and social service providers need to address issues of Aboriginal language and daily cultural practice when interacting with First Nations, Inuit and Métis elders with disabilities. Many Aboriginal elders who are 65 years and over communicate primarily in their Aboriginal mother tongue. The 2001 Census found that 79% of Inuit elders converse regularly in Inuktitut while the 1997 First Nations and Regional Health Survey conducted across 183 First Nation communities and five Labrador Inuit communities indicated that 52% of elders who were 65 and over use an Aboriginal language most often in daily life.[97] Aboriginal elders are also likely to have lower levels of education and to communicate orally and this needs to be taken into account when communicating health information.

The 2002 RHS identified a number of obstacles to obtaining needed health care by First Nations people with disabilities living on First Nations reserves. While these are not necessarily representative of all Aboriginal people with disabilities or of elders, they are informative. Further, people with disabilities were more likely to report these barriers than were those without disabilities. Some barriers included: doctor or nurse not in respondent's area (24%); service was not available in respondent's area (22%); unable to arrange transportation (23%); could not afford transportation (23%); and felt service was not culturally appropriate (21%). In addition to obstacles preventing access to medical care, 41% of First Nations adults with disabilities indicated they had difficulty accessing traditional medicines.[98]

■ INCOME

Along with a range of social factors, income is one of the major determinants of health according to the Public Health Agency of

Canada.[99] Income level has an impact on an individual's ability to maintain their well-being and address their health needs in general, and in particular any extraordinary needs resulting from their disability.

Lack of sufficient income hampers an individual's ability to find adequate housing and to modify that housing to meet their disability needs; it prevents access to services and information; it affects food choices and therefore can undermine health in children and pregnant women in particular; and it limits social inclusion. For Aboriginal people whose personal and financial resources are stretched in many ways, dealing with a disability or a family member with a disability is all the more financially and personally difficult.

4 in 10 (38%) First Nations elders with disabilities age 55 and over living on reserve have household incomes below $20,000

Those with limited income and living in an area with limited local services do not have the resources for travel to another location to find services or to pay for services that are not covered by provincial or federal programs.

Figure 7.5 shows pre-tax household incomes of elders age 65 and older. Household incomes of Aboriginal male elders with disabilities are generally lower than those of their fellow male elders without disabilities. Women elders with and without disabilities have similar incomes to one another. However, their household incomes are significantly lower than those of men. Although a precise comparison to after-tax household incomes shown for non-Aboriginal seniors in Figure 6.1 (See Chapter 6) is not possible, it seems clear that household incomes for Aboriginal elders with disabilities are substantially lower.

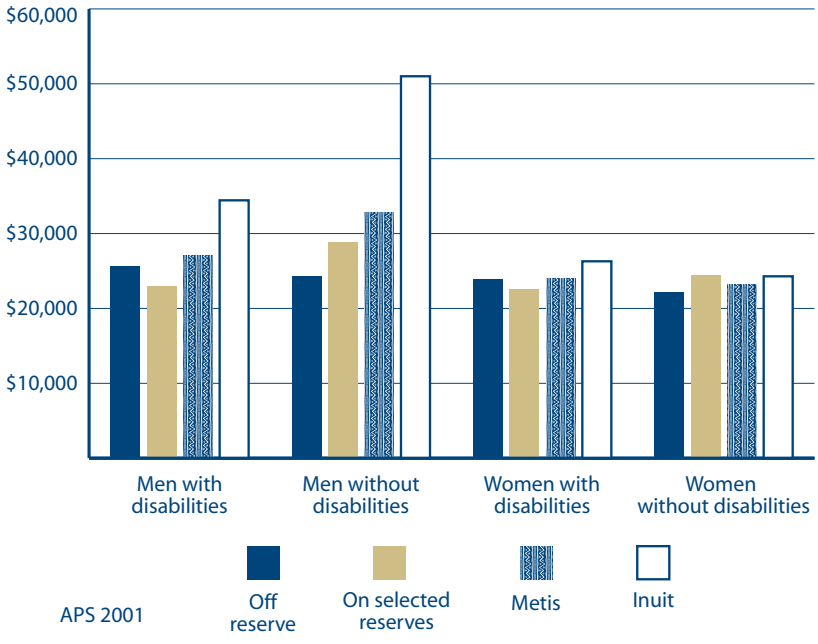
Chapter 6 discussed the low income rate for seniors with disabilities using the Statistics Canada Low Income Cut-Off (LICO). The LICO measure is not defined for First Nations communities nor for remote northern regions. Therefore, the following discussion defines low income as a household income of less than $20,000 per year and addresses the situation of elders age 55 and older.

While 23% of all Aboriginal elders without disabilities have low household incomes—already a substantial number—those numbers increase substantially for Aboriginal men and women with a disability. This is true for all Aboriginal groups, but the frequency is highest for First Nations people living on selected reserves where 4 in 10 (38%) elders with disabilities age 55 and over have household incomes below $20,000.

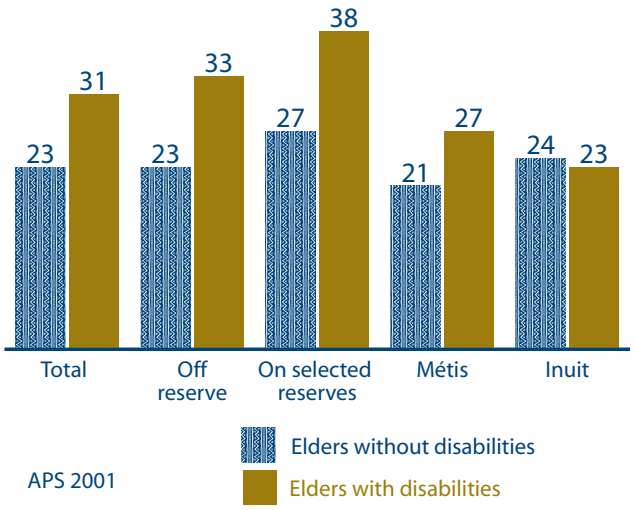
Figures 7.5 and 7.6 both suggest that Inuit elders have higher incomes than other groups. However, it is important to remember that costs of food, transportation and other items are generally much higher in the north than in other areas of the country.

When examining low income differences between Aboriginal women and men age 55 and

7.5 Median household pre-tax income-Aboriginal elders 65 and older



7.6 Aboriginal elders (55 and over) by group: household income lower than $20,000 (%)



over with disabilities, the data show that women elders with disabilities are more likely to report family incomes below $20,000. This is especially so on selected First Nation reserves where 50% of women elders with disabilities live with low income.

By comparison, among the general population age 55 and over, 16% have a household income below $20,000, while the rates are 21% for people with disabilities and 13% for those without disabilities. Among non-Aboriginal women with disabilities age 55 and over, 26% have household incomes below $20,000 and (14% of men do so).

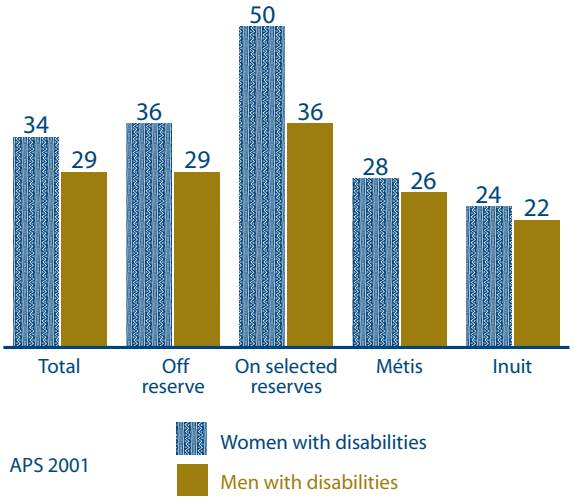
Having paid employment is often the key to economic independence and full participation in the community. Aboriginal people generally earn less over their lifetimes than their non-Aboriginal counterparts and face additional barriers to employment, such as low educational attainment, and fewer business opportunities. The 2001 APS notes that the unemployment rate of Aboriginal peoples is two-and-a-half times higher than that of other Canadians.

This weak labour force attachment has a direct and negative impact on income security during the senior years. It means many Aboriginal people—in particular Aboriginal people with disabilities—rely almost solely on Old Age Security (OAS) and the Guaranteed Income Supplement (GIS) after the age of 65. They have not had the opportunity to save, to use retirement investment vehicles, or to accumulate Canada Pension Plan or Canada Pension Plan Disability benefits.

The APS asks respondents to identify their sources of income. Some 96% of Aboriginal women elders with disabilities age 65 and over, receive OAS with little variation by group for women. For Aboriginal men with disabilities age 65 and over, the lowest rate of receipt is among First Nations living off reserve (90%) and the highest rate of receipt is among Inuit en (98%).

The percentage of Aboriginal people with disabilities age 65 and over who receive Canada Pension Plan benefits varies more widely, and overall the rates are lower. For Aboriginal women with disabilities, the range is 28% to 79%, with significantly lower rates for First Nations women with disabilities living on reserve (46%), and Inuit women (28%). For Aboriginal men with disabilities, the rate ranges from 48% to 91%, with the lowest rates for Inuit men (48%), and 54% for First Nations men with disabilities living on reserve. This may be due to many factors, but chief among them are labour force attachment during their working lives and the lower accrual of benefits.

7.7 Aboriginal elders (55 and over) with disability by sex: household Income lower than $20,000 (%)



CONCLUSION

This chapter has provided a brief overview of a few of the key issues facing First Nations, Métis and Inuit elders with disabilities and their communities. Limitations in data sources and space have prevented a more comprehensive examination. Nonetheless, it seems clear that many of the issues affecting all seniors with disabilities are the same issues that affect Aboriginal elders with disabilities. Elders with disabilities have difficulty obtaining the housing supports they need, their health is worse than that of elders without disabilities and they experience low income in disproportionate numbers. Aboriginal elders have additional concerns. These include accessing culturally-appropriate health care, addressing language and cultural barriers, overcoming geographic isolation and ensuring continuing community supports even when away from their home community. Addressing these issues will go a long way in meeting the needs of Aboriginal elders with disabilities. To do so will require the collaboration of governments, Aboriginal leaders and the wisdom of First Nations, Métis and Inuit elders with disabilities themselves.

GOVERNMENT ACTION ADDRESSING NEEDS OF FIRST NATIONS, MÉTIS AND INUIT ELDERS WITH DISABILITIES

CANADA MORTGAGE AND HOUSING CORPORATION

- Residential Rehabilitation Program for Persons with Disabilities
- *Residential Rehabilitation Program—Secondary/Garden* Suite
- Home Adaptations for Seniors Independence

HEALTH CANADA

- First Nations and Inuit Home and Community Care Program*
- Non-insured Health Benefits Program for First Nations and Inuit People*
- Aboriginal Diabetes Initiative*

INDIAN AND NORTHERN AFFAIRS CANADA

- Assisted Living Program*
- Income Assistance Program*

* These programs are only partially targeted to people with disabilities. See the discussion of “partially- targeted measures” in Chapter 9.

CHAPTER 8
POLICY DEVELOPMENTS

ADVANCING THE inclusion of the 3.6 million Canadians with disabilities in their communities, work, school and all aspects of society is an ongoing focus of the Government's policy agenda.

Achieving full inclusion requires an active strategy to remove barriers such as lack of accessibility and discrimination while also implementing new supportive measures and leading by example. Inclusion may be advanced by ensuring that broad initiatives such as Early Learning and Childcare and the National Action Plan for Seniors and Caregiving fully embrace people with disabilities. Inclusion can also be advanced by implementing new disability-specific measures and by enhancements to existing measures such as the disability supports deduction.

This chapter reviews significant developments occurring over the past 12 months resulting in improved Government of Canada support for people with disabilities. Having completed the implementation of several specific initiatives, the Government is also working with provinces, territories and stakeholders on others. This work is building on the policy vision of *In Unison*—a framework endorsed by federal, provincial and territorial governments since 1998.[100] Table 8.1 summarizes important milestones since the fall of 2004.

■ CONTINUING TO IMPROVE TAX FAIRNESS

The past year built on the significant steps taken in recent years to enhance tax fairness for people with disabilities. The stage was set for the latest changes when the Technical Advisory Committee on Tax Measures for Persons with Disabilities submitted its report to the Ministers of Finance and National Revenue in December 2004. This fulfilled the Committee's mandate to make recommendations that would improve the fairness of treatment of people with disabilities under the income tax system.

The Committee's report, *Disability Tax Fairness*, made recommendations covering three broad themes:[101]

- Clarifications to the legislative and interpretive intent of the disability tax credit and improvements to its administration;
- Improvements to tax measures that enable people with disabilities to pursue education, training or employment; and
- Changes to improve tax measures that recognize the additional costs of caregiving.

In concluding its report, the Technical Advisory Committee recommended that in going forward the government should also look beyond the tax system and give priority to expenditure programs.

In the 2005 Budget, the Government of Canada implemented the vast majority of the Technical Advisory Committee's recommendations.

DISABILITY TAX CREDIT

Budget 2005 extended eligibility for the disability tax credit (DTC) to individuals who face multiple restrictions that together have a substantial impact on their everyday lives. It also amended the DTC to ensure that more individuals requiring extensive life-sustaining therapy on an ongoing basis are eligible. It clarified other

parts of the DTC eligibility criteria, including the provisions dealing with impairments in mental function, and it added physiotherapists to the list of health professionals who can certify eligibility for the DTC.

DISABILITY SUPPORTS DEDUCTION

Budget 2005 expanded the list of expenses eligible for the disability supports deduction introduced in Budget 2004 to include costs such as: Braille note-takers, job coaches, and deaf-blind interveners. This deduction ensures that income (including government assistance) used to pay for eligible disability supports incurred for education or employment purposes is not taxed and does not affect income-tested benefits.

REFUNDABLE MEDICAL EXPENSE SUPPLEMENT

Budget 2005 increased the maximum amount of the refundable medical expense supplement from $571 to $750 per year. This measure improves work incentives for Canadians with disabilities and others with above-average medical expenses by helping to offset the loss of disability-related benefits under provincial social assistance programs when they enter the paid labour force. It provides assistance for above-average disability and medical expenses to low-income working Canadians.

REGISTERED EDUCATION SAVINGS PLAN (RESPS)

The Budget extended, for DTC eligible students, the contribution period for individual registered education savings plan (RESPs) to 25 years from 21 years and the lifetime limit of individual RESPs to 30 years from 25 years.

CHILD DISABILITY BENEFIT

Budget 2005 increased the maximum annual Child Disability Benefit to $2,000 from $1,681 per child beginning in July 2005.

MEDICAL EXPENSE TAX CREDIT

In addition to the measures adopted in response to the Technical Advisory Committee's advice, Budget 2005 proposed additional changes to the medical expense tax credit (METC). Budget 2005 expanded the list of expenses eligible for the METC to include items such as Braille note-takers and deaf-blind interveners, at an annual cost of $5 million. Budget 2005 also doubled, to $10,000, the maximum amount of medical and disability-related expenses that caregivers can claim on behalf of their dependent relatives under the METC, at a cost of $15 million in 2005–06.

The METC recognizes the effect of above-average disability-related and medical expenses on an individual's ability to pay tax. For 2005, the credit equals 16% of qualifying expenses in excess of the lesser of $1,844 and 3% of net income. The net income threshold is used to determine above-average expenses and it is fully indexed to inflation. There is no upper limit on the amount of eligible expenses that may be claimed. Taxpayers may claim the medical expenses that they or their spouses incur as well as, in certain circumstances, expenses incurred by specified dependent relatives.

IMPROVING ADMINISTRATION OF DISABILITY TAX MEASURES

In July 2005, the Canada Revenue Agency formed the Disability Advisory Committee to address the administrative aspects of the disability tax credit and the implementation of the Technical Advisory Committee report's recommendations. The committee is made up of consumer and professional representatives and reports directly to the Minister of National Revenue on all administrative aspects of the tax system related to people with disabilities.

■ PROGRAM CHANGES AND INVESTMENTS

Beyond making improvements in the tax system, the Government made some significant

TABLE 8.1 Key disability milestones from fall 2004 to fall 2005	
December 2004	*Advancing the Inclusion of Persons with Disabilities*—2004 published. Provincial governments release their benchmark reports under the Labour Market Agreements for Persons with Disabilities
December 2004	FPT Ministers release *Supports and Services for Adults and Children aged 5-14 in Canada: An analysis of data on needs and gaps*
December 2004	Technical Advisory Committee on Tax Measures for Persons with Disabilities submits its report to Ministers of Finance and Revenue
December 2004	Veterans Independence Program expanded to provide benefits to additional primary caregivers including eligible spouses and common law partners for life
January 2005	CPP Disability automatic reinstatement goes into effect
February 2005	Budget 2005 includes: • action on virtually all of the recommendations of the Technical Advisory Committee on Tax Measures for Persons with Disabilities • funding to the Canadian National Institute for the Blind to digitize the CNIB library • funding to support the 2010 Paralympic Games • other more general measures benefiting Canadians with disabilities including increases to the Guaranteed Income Supplement and the Integrated Strategy on Healthy Living and Chronic Disease
March-April 2005	Disability organizations, provinces, territories, federal government departments and researchers invited to provide input on the content of PALS 2006
May 2005	The new Veterans Charter receives Royal Assent. The new Charter will enable Veterans Affairs Canada to modernize services, assistance and compensation to Canadian Forces members, Veterans and their families.
May 2005	Government announces Canada Mortgage and Housing Corporation's Residential Rehabilitation Program—Secondary/Garden Suites program
June 2005	House of Commons Subcommittee on the Status of Persons with Disabilities submits report *Accessibility for All*
April-October 2005	Listening to Canadians consultation workbooks available for Canadians to provide their views to Government on caregiving, seniors and disability
October 2005	Government tables its response to *Accessibility for All*
October 2005	FPT Ministers responsible for Social Services confirm the priority of work to improve access to and funding for disability supports and income supports
October 2005	FPT Ministers of Health approve the *Integrated Pan-Canadian Healthy Living Strategy* (intersectoral) Government launches the *Integrated Strategy on Healthy Living and Chronic Disease* (federal)

one-time investments and ongoing changes to support people with disabilities.

As described in detail in Chapter 9, new investments were announced to assist Canadians with print disabilities and to support participation of Canadian athletes with disabilities in the 2010 Paralympics.

Among important program developments were the implementation of CPP Disability automatic reinstatement, the continuation of the Canadian Diabetes Strategy, the implementation of a new Veterans Charter, announcement of the Residential Rehabilitation Assistance Program—Secondary/Garden Suite program, and administrative improvements in the Social Development Partnerships Program.

CPP DISABILITY

In January of 2005, an automatic reinstatement provision was implemented in the Canada Pension Plan Disability program. As discussed in last year's report, this provision allows for quick reinstatement of benefits for CPPD clients whose benefits were stopped because they returned to work and who subsequently find that they cannot continue working because their disability recurs. The change was needed because the possibility of losing benefits was a major obstacle hindering clients who wanted to try returning to work. Between January 31, 2005 and July 31, 2005, 708 CPPD clients reported a return to work and had their benefits stopped. Of those, 38 subsequently resumed their benefits using the automatic reinstatement provision.

CANADIAN DIABETES STRATEGY

The *Canadian Diabetes Strategy* (CDS) was implemented as a five-year initiative in 1999 and extended for one year in 2004-2005. Budget 2005 provided a further one year extension. The prevention and promotion component of the Strategy helps raise public awareness about diabetes, its risk factors, and complications, promotes behaviours and skills to reduce incidence and prevalence of diabetes and focuses on community capacity building to engage at-risk populations in diabetes prevention efforts. Over the past six years, contribution agreements have supported the implementation of over 150 community projects nationally and in each region of Canada. The Canadian Diabetes Strategy has been particularly successful in increasing community capacity and awareness; creating enabling environments through policies related to healthier food choices and increased physical activity in schools and seniors residences; and promoting healthy lifestyle practices and lifestyle change.

VETERANS CHARTER

The new Veterans Charter, which received Royal Assent on May 13, 2005, recognizes the contribution of Canada's younger modern-day Canadian Forces (CF) members to Canada as a country, and to the world community. The Veterans Charter responds to their unique needs by offering a comprehensive 'wellness package' of programs designed to provide CF members and their families with the best opportunity for a successful transition to an independent and productive civilian life. CF Veterans will be able to enjoy the best health possible, have the optimal chance for a quality job and, when necessary, receive earnings loss support. CF Veterans will have a single point of entry to a comprehensive suite of services and programs through a dedicated Veterans Affairs Canada (VAC) Case Manager. The key elements of the services and programs are: rehabilitation services and vocational assistance, health benefits, job placement assistance, economic loss support, disability awards and case management.

VETERANS MENTAL HEALTH

The development of Veterans Affairs and National Defence's *Strategy for the Assessment and Treatment of Post-Traumatic Stress Disorder and other Psychological Injuries* is expected to lead to a coordinated Mental Health Care Delivery System. This system will provide comprehensive diagnosis, treatment and monitoring for Canadian Forces members, Veteran pensioners and members who are releasing from the Canadian Forces and making the transition to civilian life. It will also allow the two federal departments to continually improve access to mental health services for Veterans and members regardless of their geographical location.

VAC is also leading an international working group that has developed a catalogue entitled, *International Approaches to Treatment and Support of those with Service-related Mental Health Needs and Injuries*. This working group is in the process of developing an international protocol for the prevention, diagnosis, treatment and recovery phase of Operational Stress Injuries arising from military service.

RESIDENTIAL REHABILITATION ASSISTANCE PROGRAM—SECONDARY/ GARDEN SUITE

The Residential Rehabilitation Assistance Program—Secondary/Garden Suite was announced in May 2005 to assist in the creation of affordable housing for low-income seniors and adults with a disability by providing financial assistance to convert/develop existing residential properties that can reasonably accommodate a secondary self-contained unit. Assistance is provided to eligible homeowners, private entrepreneurs and First Nations in the form of a fully forgivable loan that does not have to be repaid provided the owner adheres to the conditions of the program.

SOCIAL DEVELOPMENT PARTNERSHIPS PROGRAM/DISABILITY COMPONENT

The Social Development Partnerships Program's, disability component (SDPP/D) is an important part of the Government's support to people with disabilities. Each year, subject to available resources, SDPP/D funds disability-related projects proposed by disability organizations and other non-profit organizations. In 2005, SDPP/D implemented administrative changes to simplify the work involved in applying for funds and to improve the alignment of funding with achievement of program objectives. SDPP/D aims to support greater cooperation among the disability community, researchers, policy analysts and others through its financial support to collaborative partnerships and social development projects across Canada.

PARLIAMENTARY COMMITTEES

House of Commons Subcommittee report: *Accessibility for All*

An important development in the past year was the publication of a report by the House of Commons Standing Committee on Human Resources and Skills Development, Social Development and the Status of Persons with Disabilities. Since 1998, this committee has played an important role in bringing forward issues and obstacles faced by people with disabilities. In June of 2005 the committee's latest report titled *Accessibility for All*[102] was tabled.

The Government provided its response to *Accessibility for All* in October of 2005. In its response, the Government agreed with the Committee's assessment that accessibility to the services, programs and public goods provided within the federal jurisdiction is essential to inclusion. The response highlighted the many accomplishments that have occurred over the past 25 years and acknowledged that much remains to be done. The Government committed itself to continuing to improve access to government buildings, public service employment and services within federal jurisdiction; continuing to work to remove barriers in federally-regulated transportation; improving research and knowledge development; and examining legislative and regulatory mechanisms to increase coherence. The response also highlighted the need to continue working with other orders of government, private and non-profit voluntary sectors, employers, labour and individual Canadians in order to address the full range of barriers hindering inclusion of persons with disabilities.

Senate Committee Hearings on Mental Health and Mental Illness

The Senate Standing Committee on Social Affairs, Science and Technology began conducting an examination of issues associated with mental health and mental illness in the spring of 2003 and is expected to submit its final report in December 2005. Mental health problems are a significant contributor to disabilities in Canada. For example, PALS 2001 estimated that over 500,000 Canadian adults had "psychological" disabilities, while the proportion of CPP Disability beneficiaries due to mental disorders has grown from 11% in 1980 to 26% in 2004. The Government anticipates that the final report of the Senate committee will be a significant source of information in the ongoing development of disability policy.

■ LISTENING TO CANADIANS

In 2005, the Government engaged Canadians on a number of important social issues including caregiving, seniors, and disabilities. Roundtables with groups of individuals and organizations provided an opportunity for people to voice their views and their vision for the future. The Government provided resource kits to Members of Parliament to support them in conducting public dialogue sessions with constituents on these issues. Canadians were also offered opportunities to complete consultation workbooks on any of these topics.

Engagement activities surrounding disability issues in 2005 built on the results of Environics public opinion research the Government sponsored in early 2004.[104] Consultation workbooks were designed to increase understanding of disability issues, to allow Canadians to tell their stories and to express their opinions about different policy directions. With the support of disability organizations who alerted their members to this opportunity over 300 Canadians took the time to complete a disability workbook.

In March and April of 2005, national disability organizations, researchers, provincial and territorial governments and Government of Canada departments were asked to provide their views on the desired content of the 2006 Participation and Activity Limitation Survey (PALS 2006). Like its predecessor in 2001, PALS 2006

will provide a detailed profile of Canadians with disabilities living in private households. The 2006 survey will be designed to allow comparisons with 2001 in order to measure changes in disability issues. The input received will help to identify important new information requirements as well as the priorities for retaining content from 2001.

■ ONGOING DEVELOPMENTS

UNITED NATIONS CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES

Since 2002, the Government has been leading Canada's participation in a United Nations ad hoc Committee on Human Rights of Persons with Disabilities. This ad hoc committee is negotiating a draft text for a possible new UN Convention on the Rights of Persons with Disabilities. The Government has sought input from provincial and territorial governments and disability organizations as work on the draft convention has advanced. At this time, the ad hoc committee has held six meetings and is moving into final negotiations that are expected to last another year or so. Once the text is finalized by the UN it will be up to each member state to determine whether to sign and ratify the convention.

REVIEW OF THE OPPORTUNITIES FUND

Since 1997, the Opportunities Fund has supported improved employability of people with disabilities who have had little or no attachment to the labour force. The Government is working with disability organizations and other stakeholders to review the scope and direction of this program. This review is driven by two factors:

- The potential overlap of Opportunities Fund programming with other labour market programming provided under the Multilateral Framework for Labour Market Agreements for Persons with Disabilities (LMAPD) and under Employment Insurance (EI); and
- The recognition of a need to more closely align the program with Social Development Canada's mandate and to strengthen its community focus.

The Government expects to develop a new vision, objectives, outcomes and core activities for a renewed Opportunities Fund by the summer of 2006.

FEDERAL, PROVINCIAL, TERRITORIAL WORK ON DISABILITY ISSUES

In 1996, First Ministers identified Canadians with disabilities as a collective priority, launching collaborative work between federal, provincial and territorial governments. This commitment was elaborated in 1998 with the release of *In Unison* which outlined a vision for full inclusion of people with disabilities with a focus on the three 'building blocks' of disability supports, income and employment to achieve this vision.

To date, the focus has been primarily on improving employment and learning opportunities for people with disabilities. Notable progress has been made in this area in recent years through the LMAPD.

In October 2005, the Federal/Provincial/Territorial Forum of Ministers responsible for Social Services affirmed that a key priority for the forum over the next year will be persons with disabilities. Ministers reaffirmed their commitment to the objective of the full inclusion of Canadians with disabilities in society. The focus for achieving this objective will be joint work with emphasis on improving access to and funding for disability supports and services and for income supports for persons with disabilities. At the same time work will continue on building public awareness and stakeholder and government support to address the challenges facing people with disabilities. At their next meeting, Ministers will consider jointly developed options in these areas that address both the short- and longer-term aspects of achieving this objective.

■ A CHANGING ENVIRONMENT

The vision of full citizenship and inclusion through improved disability supports, employment and income painted in *In Unison* continues to guide the Government's disability agenda. However, other factors are being recognized that should be taken into account in shaping policy to achieve that vision. For example, the role of local communities is a key development not fully incorporated into *In Unison*. Other important challenges include the growing numbers of seniors with disabilities, the high rates of disability among Aboriginal peoples and the "double disadvantage" faced by many Aboriginal people with disabilities. Changing family structures, ongoing shifts in the economy, changes in health care and technology, changes in the causes and types of disabilities, and increased ethnic diversity must also be considered.

■ MAPPING INITIATIVES TO THE REPORTING FRAMEWORK

Table 8.2 maps initiatives reviewed in this chapter to the overall accountability framework introduced in Chapter 1. As shown in the table, action has occurred in all the outcome areas. In addition, the Government is working to ensure a solid base of information to guide future policy work. The next chapter will examine the Government's expenditures on disability-related initiatives using the same framework.

TABLE 8.2 Linking the major developments of the past year to the accountability framework		
AREA	**PROGRAMS AND OTHER INITIATIVES**	**TAX MEASURES**
Skills Development and Learning		Improved RESP provisions for those who are eligible for the DTC
Employment	▸ Opportunities Fund review ▸ CPPD Automatic Reinstatement	
Capacity of the Disability Community	Streamlined SDPP/D funding application process	
Disability Supports	▸ Support for CNIB digital library ▸ Library and Archives Canada ongoing funding for improved accessible services ▸ FPT Ministers work on short and long-term options ▸ Support for 2010 Winter Games-commitment to accessibility and Paralympics ▸ Extension for life of Veterans Independence Program housekeeping and grounds maintenance services to primary caregivers of Veterans. ▸ RRAP—Secondary/Garden suites	Enhanced disability supports deduction, medical expense tax credit, and refundable medical expense supplement
Health and Well-being	▸ F/P/T Ministers committed to advancing the Pan-Canadian Healthy Living Strategy ▸ New Veterans Charter will provide a comprehensive range of modernized programs and services to Canadian Forces members, Veterans and their families.	
Income	Increases to Guaranteed Income Supplement	Expanded eligibility for the Disability Tax Credit
Increasing Knowledge	Ongoing development of PALS 2006 ▸ Listening to Canadians (workbooks and roundtables)	

CHAPTER 9
DISABILITY EXPENDITURES

BUDGET 2005 HIGHLIGHTS FOR PEOPLE WITH DISABILITIES

Budget 2005 announced a variety of measures directly or indirectly addressing the needs of people with disabilities. Continuing the pattern of recent years, the budget built on the significant steps taken in recent years to enhance tax fairness for people with disabilities while also introducing targeted spending initiatives to meet specific needs.

BUDGET MEASURES DIRECTLY ADDRESSING PEOPLE WITH DISABILITIES

Tax measures

As described in Chapter 8, the Government of Canada implemented the vast majority of the recommendations from the Technical Advisory Committee on Tax Measures for Persons with Disabilities. Taken together, these measures will increase tax relief for people with disabilities and their caregivers by $105 million in 2005-2006, growing to $120 million by 2009-2010. Further, funding for the Canada Revenue Agency has been increased by $2 million per year to improve its administration of the disability tax credit and other disability-related tax measures.

In addition to the measures adopted in response to the Technical Advisory Committee's advice, Budget 2005 doubled, to $10,000, the maximum amount of medical and disability-related expenses that caregivers can claim on behalf of their dependent relatives under the METC.

Expenditures for Canadians with print disabilities

Budget 2005 allocated funding to improve the accessibility of information for print-disabled Canadians. This includes a $6 million contribution in 2005-2006 to the Canadian National Institute for the Blind (CNIB). These funds will help the CNIB to digitize its collection to broaden its library services to print-disabled Canadians across the country. As well, the Budget provided $1 million per year from 2006-2009 to Library and Archives Canada to improve access to information for print-disabled Canadians. Together these funds will help millions of Canadians with print disabilities to participate more fully in all aspects of Canadian society by improving the accessibility of information and written culture.

2010 Olympics and Paralympics

In 2010, the eyes of the world will be on Canada as Vancouver and Whistler host the Olympic and Paralympic Winter Games. Canada is committed to ensuring that the venues and facilities developed for the Games meet the highest standards of accessibility. In addition to providing substantial financial support for building the Olympic facilities, the Government announced $20 million to support the training and participation of the athletes who will represent Canada at the 2010 Paralympic Winter Games.

The Budget also increased funding for community level initiatives to increase sport participation by Canadians with and without disabilities by $5 million per year bringing this ongoing funding to $15 million per year.

■ BUDGET HIGHLIGHTS FOR SENIORS WITH SPECIAL RELEVANCE TO SENIORS WITH DISABILITIES

In addition to the items above, the Budget introduced other measures that will benefit seniors with disabilities along with other Canadian seniors.

The Guaranteed Income Supplement (GIS) provides a basic level of benefit for low-income seniors, many of whom are seniors with disabilities. Budget 2005 increased the monthly amount of the GIS by $36 for singles and $58 for couples at a total cost of $2.7 billion over five years.

Budget 2005 increased funding for the New Horizons for Seniors program to $25 million annually by 2007-2008. New Horizons provides funding to projects that enable seniors' social participation, active living and contributions to their community. Seniors with disabilities can participate in all aspects of funded projects while all seniors with disabilities living in the community may benefit from project results.

The budget also announced funding of $13 million over five years to establish a National Seniors Secretariat in Social Development Canada to serve as a focal point within the Government for collaborative efforts to address the issues facing seniors. The Secretariat will work with other federal departments, provincial and territorial partners, seniors' organizations, and Canadians to build on the valuable work being done to support seniors. Its work will be complementary to that of the Division of Aging and Seniors at the Public Health Agency of Canada which focuses on the health and well-being issues of seniors.

■ OTHER IMPORTANT MEASURES OF INTEREST TO PEOPLE WITH DISABILITIES

The budget allocated $300 million over five years to a new **Integrated Strategy on Healthy Living and Chronic Disease** to encourage healthy living and prevent and control chronic disease.

■ GOVERNMENT OF CANADA DISABILITY EXPENDITURES

The Government supports Canadians with disabilities through ongoing program expenditures and tax measures. Last year's report on disability introduced an approach for classifying Government expenditures in order to determine which ones should be included in an analysis of disability expenditures. Using this approach, expenditures are classified as:

FULLY-TARGETED MEASURES: exclusively targeted to people with disabilities and their families. Examples include the disability tax credit, the Canada Pension Plan Disability benefit, Residential Rehabilitation Assistance Program—Disability, or Canada Study Grants for students with disabilities.

PARTIALLY-TARGETED MEASURES: may have a significant disability-related component but it is difficult to determine the precise amount that is disability related. Examples of partially-targeted measures include the medical expense tax credit, Employment Insurance Sickness Benefits, Health Canada's non-insured health benefits program and Veterans Affairs' Veterans Treatment Benefits Program.

MEASURES FOR THE GENERAL POPULATION: intended to benefit population groups without regard for their disability status. Such measures should be designed so that they do not inadvertently exclude people with disabilities. Examples include Employment Insurance, Registered Education Savings Plans and the pension income credit (tax credit).

In the following analysis, fully-targeted measures are included while measures for the general population are not included. A few partially-targeted measures are also included to provide comparability to previous reports while not artificially inflating the estimated expenditures.

Government of Canada disability expenditures in 2004-05 totalled $7,634.7 million, including $6,114.7 million in programs and $1,520.0 million in tax measures for people with disabilities. This overall amount represents an increase of 5.8% over total expenditures in 2003-2004.

The total amount of tax measures in the 2005 tax year increased by 13.0% compared to 2004. Overall program benefits increased by 4.1% between 2003-2004 and 2004-2005.

The Government's principal disability benefits and program expenditures are presented in Appendix A and summarized in Table 9.1. As shown in the table, income measures, representing approximately 71% of the Government's disability-related expenditures, are the largest area of spending. CPP Disability is the country's largest disability program, with the Government also providing pensions to Veterans in compensation for disability suffered as a result of service. Federal workers compensation benefits and Employment Insurance Sickness Benefits also provide income support on a temporary basis to eligible individuals who cannot work due to disability or sickness.

Tax measures represent the second largest area of disability expenditures at about 20%. With measures announced in the 2005 budget, it is anticipated that total tax expenditures will continue to grow.

Skills development, learning and employment, are the third largest area, representing nearly five percent of Government expenditures. Growth in this area from 2003 to 2004 resulted from the increase of $30 million allocated to the labour market agreements for people with disabilities and from the new Canada Study Grants for High-Need Students with Permanent Disabilities. Both measures were announced in Budget 2004.

Programs supporting home modifications for accessibility and safety administered by the Canada Mortgage and Housing Corporation along with the Veterans Independence Program from Veterans Affairs represent the Government's major contribution to disability supports. Expenditures under both of these programs increased from 2003 to 2004. It is worth noting that several large, partially-targeted programs fund disability supports required by Veterans and

TABLE 9.1 Summary of Government of Canada Disability Expenditures ($M)

AREA	2003-04	2004-05	PERCENT OF 2004-05	PERCENT CHANGE (2003 TO 2004)
Skills Development, Learning and Employment	333.3	358.2	4.7%	6.1%
Capacity of the Disability Community[1]	17.2	16.5	0.2%	-4.1%
Disability Supports	217.8	253.4	3.3%	16.3%
Health and Well-being[1]	56.7	58.0	0.8%	2.4%
Income[1]	5,247.8	5,428.6	71.1%	3.4%
TOTAL PROGRAMS	**5,872.8**	**6,114.7**	**80.1%**	**4.1%**
Tax measures[2]	1,345.0	1,520.0	19.9%	13.0%
TOTAL[1]	**7,217.8**	**7,634.7**		**5.8%**

[1] Amounts shown for 2003-2004 are revised from the estimates provided in the 2004 report
[2] Numbers for tax measures are for the 2004 and 2005 tax years respectively

First Nations and Inuit, however, expenditures for these programs are not included in the totals shown in Table 9.1.

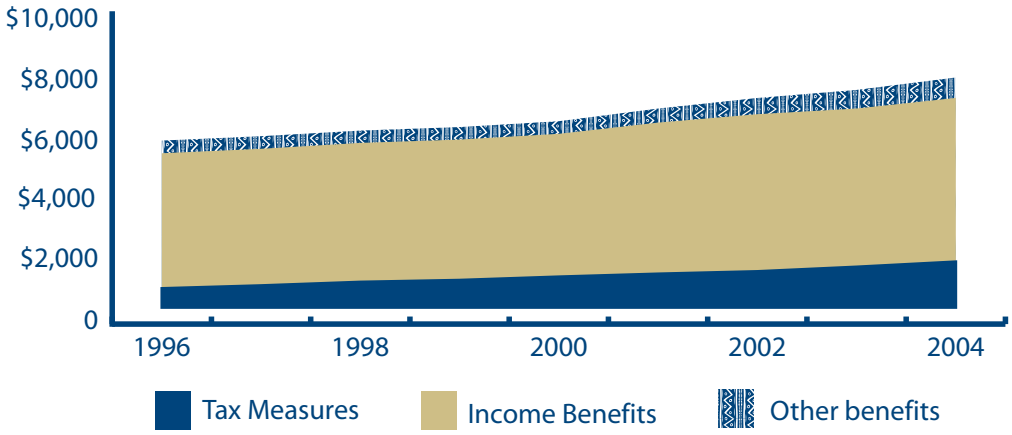
Combined program expenditures in Health and Well-being and Capacity of the Disability Community represent about one percent of the Government's total disability expenditures. The changes in expenditures from 2003-2004 to 2004-2005 results from the ending of the Falls Prevention Initiative and the net effect of normal fluctuations in grants and contributions from the other programs making up these two categories.

HISTORICAL TREND

Figure 9.1 shows the trend in overall Government of Canada disability expenditures since 1996. The figure shows that expenditures have increased by about 38% over that period of time. Over the same period, the consumer price index increased by 17.7%.

Since 1996, the amount represented by tax measures has more than doubled. Over that same period, total income-related benefits have increased by about 20% while other program benefits have increased by 60%.

9.1 Disability benefits, services and tax measures ($millions) 1996-2004



PART 3
REPORTING ON THE LABOUR MARKET AGREEMENTS FOR PERSONS WITH DISABILITIES

HIGHLIGHTS

- The employment rate for women with disabilities has improved significantly: from 38% in 2001 to 43% in 2003
- The percentage of women with disabilities with a post-secondary diploma has risen from 37% in 2001 to 41% in 2003; for women without disabilities 46% had a post-secondary diploma in 2001 rising to 49% in 2003
- While still low compared to men with and without disabilities, the average earnings for women with disabilities have risen: from $21,400 in 2001 to $24,400 in 2003. The average income for women without disabilities was $26,500 in 2001 and $26,100 in 2003

THIS THIRD part of the report fulfills the Government of Canada's commitment to annual reporting under the Multilateral Framework for Labour Market Agreements for Persons with Disabilities.

On April 1, 2004, the Multilateral Framework for Labour Market Agreements for Persons with Disabilities[105] replaced the Employability Assistance for Persons with Disabilities (EAPD) initiative.

Through two-year bilateral Labour Market Agreements for Persons with Disabilities (LMAPD), the Government of Canada contributes funding to provincial programs and services to improve the employment situation of Canadians with disabilities by enhancing their employability, increasing the job opportunities available to them, and building on the existing knowledge base.

Total Government of Canada funding for the Multilateral Framework for Labour Market Agreements for Persons with Disabilities is $223 million each year. Transfers to provinces are made in the amount of 50% of the costs incurred by jurisdictions for programs and services funded under the initiative, up to the amount of the Government of Canada allocation identified in the respective bilateral agreement.

While the programs and services funded under LMAPD vary among jurisdictions, reflecting their local priorities, labour market programs and services must be consistent with one or more of the following priorities: education and training, employment participation, employment opportunities, connecting employers and people with disabilities and building knowledge. The following are examples of interventions funded under LMAPD:

- job coaching and mentoring
- pre-employment training and skills upgrading
- post-secondary education
- assistive aids and devices
- wage subsidies
- employment counselling and assessment
- accessible job placement networks
- self-employment
- other workplace supports

Governments issued baseline reports on December 3, 2004 (International Day of Disabled Persons) that included program objectives, descriptions, target populations, and planned expenditures as well as societal indicators (employment rates of working-age adults with disabilities, education attainment as well as employment income/earnings).

Beginning December 3, 2005, governments will report annually on the societal indicators mentioned above and the following program indicators:

- Number of participants in programs and services;

- Number of participants completing a program or service where there is a specific start and end point to the intervention;
- Number of participants who obtained or were maintained in employment where the program or service supports this activity.

The Government of Canada will fulfill its annual reporting requirement under LMAPD through the *Advancing the Inclusion of Persons with Disabilities* reports.

TABLE III.1 LMAPD transfers

JURISDICTION	TRANSFER AMOUNT (IN MILLIONS)
British Columbia	$30.744
Alberta	$25.190
Saskatchewan	$10.853
Manitoba	$8.965
Ontario	$69.911
Québec	$45.893
New Brunswick	$5.951
Nova Scotia	$8.290
Prince Edward Island	$1.376
Newfoundland and Labrador	$4.578
Total transfers	$211.8 [a]
Government of Canada operating expenditures, including evaluation	$1.0

[a] Total transfers made to provinces and territories in 2005 were less than the total federal allocation available under LMAPD due primarily to a lapse of funds by the Government of Ontario. In addition, the Government of Canada has allocated $3.7M for bilateral agreements with the Northwest Territories, Nunavut and the Yukon. Due to outstanding fiscal issues, bilateral agreements do not currently exist with these jurisdictions.

■ GOVERNMENT OF CANADA TRANSFERS IN 2004-2005

The total amount available under LMAPD is allocated based on a formula agreed to by provinces, territories and the federal government. Amounts provided to provincial jurisdictions under LMAPD in 2004-2005 were as shown in Table III.1.

■ SOCIETAL INDICATORS

Measurement of employment rates, education attainment and employment income in the Canadian population provides a context for viewing the results of the LMAPD. Many factors in the broad economic and social environment influence the trends on each of these. Therefore, carefully designed program evaluation exercises are required to determine the extent to which LMAPD is contributing to improvements (or reducing negative impacts) in overall rates for employment, education or earnings.

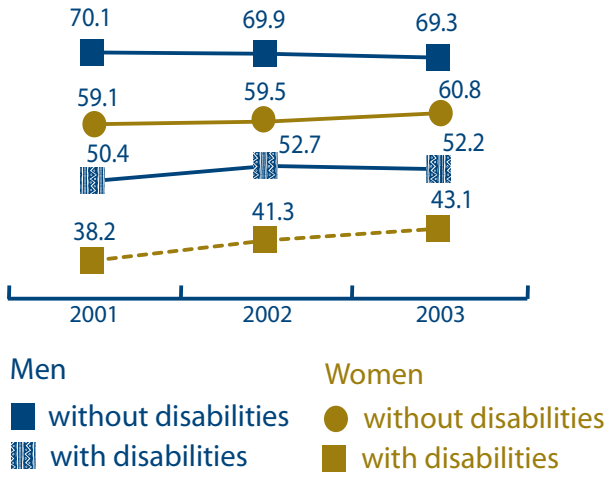
Indicators for Canada from 2001 to 2003 are presented here. Provincial governments are publishing comparable data for their jurisdictions along with program indicators.

EMPLOYMENT RATE

The employment rate for women with disabilities improved significantly between 2001 and 2003

From 2001 to 2003, the overall employment rates for the general population 16-64 years of age remained nearly constant, while the rate for people with disabilities showed a small improvement. Figure III.1 shows that the rate for women with disabilities improved significantly (from 38% in 2001 to 43% in 2003) while employment rates for men with disabilities showed only a modest gain (59% in 2001 to 61% in 2003).

III.1 Employment rates, Canada, ages 16-64 (%)



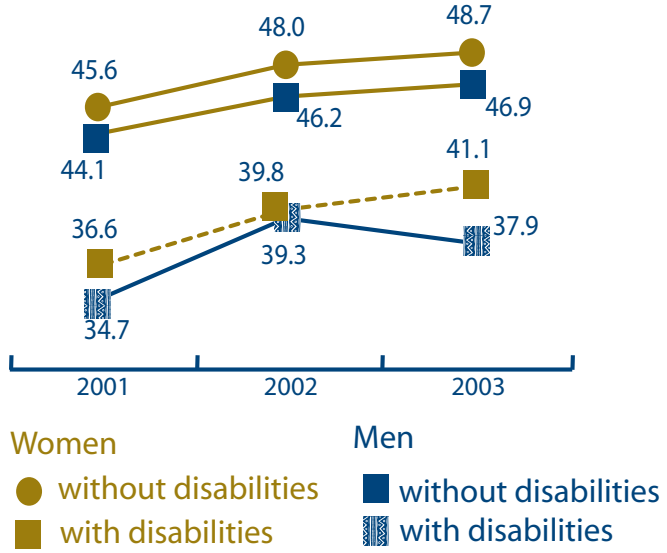
SLID 2001-2003

POST-SECONDARY EDUCATION COMPLETION

The percentage of women with disabilities with a post-secondary diploma has risen from 37% in 2001 to 41% in 2003

Post-secondary education including trade certificates, college diplomas and university degrees is increasingly required for success in today's labour market. The percentage of the population aged 16-64 who have obtained a post-secondary education certificate edged up slightly between 2001 and 2003 from 42% to 44%. Figure III.2 shows that this overall increase, however, does not apply uniformly to people with and without disabilities. Men and women without disabilities and women with disabilities were more likely to have a post-secondary certificate in 2003 than in 2001. However, the percentage of men with disabilities with a post-secondary certificate was lower in 2003 than in 2001. The result is explained by a reduced percentage of men with disabilities having university degrees, related to the fact that as the workforce is aging more men at older ages who work in occupations requiring less education are acquiring disabilities.

III.2 Post secondary certificate completions, Canada, ages 16-64 (%)

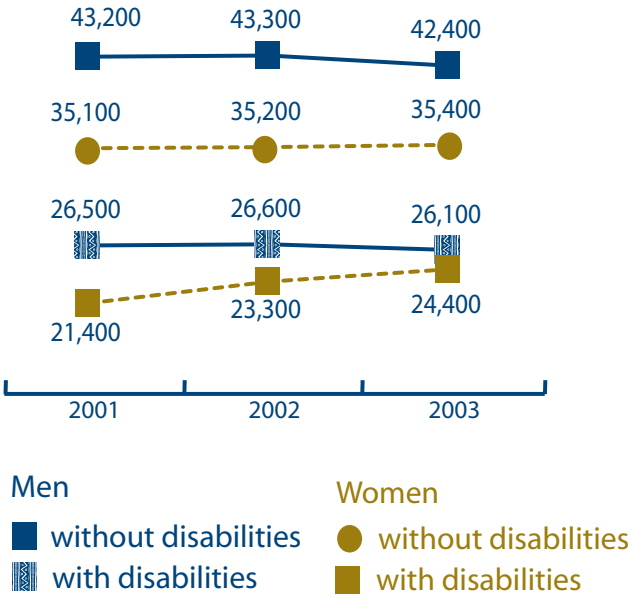


SLID 2001-2003

INCOME FROM EMPLOYMENT

While still low compared to men with and without disabilities, the average earnings for women with disabilities have risen: from $21,400 in 2001 to $24,400 in 2003. The average income for women without disabilities was $26,500 in 2001 and $26,100 in 2003.

III.3 Average earnings, Canada, ages 16-64 ($)



SLID 2001-2003

Beyond employment itself, a key measure of success in the labour market is the amount of income that individuals earn while working. Annual earnings may vary due to the number of hours worked in a year and the hourly wage so a change in average earnings may be caused by either or both of these factors.

From 2001 to 2003 average earnings for the general population decreased from $34,100 to $33,600 (in constant 2003 dollars). Figure III.3 shows that women with disabilities had increased earnings over this time period, while men with disabilities and women without disabilities had relatively flat average earnings. In contrast, men without disabilities saw an average decrease in earnings of $800 between 2001 and 2003.

APPENDIX A

GOVERNMENT OF CANADA – PRINCIPAL DISABILITY-RELATED BENEFITS AND PROGRAMS 2004-2005

PROGRAM/INITIATIVE	AMOUNT ($M/YEAR 2004-2005)
DISABILITY SUPPORTS	
CMHC programs (HASI, RRAP-D) [1]	22.7
Veterans Independence Program	230.7
SKILLS DEVELOPMENT, LEARNING AND EMPLOYMENT	
Opportunities Fund	24.1
Labour Market Agreements for Persons with Disabilities	211.8
Canada Study Grants for Students with Permanent Disabilities [2]	16.7
Canada Study Grant for High-Need Students with Permanent Disabilities	3.6
Aboriginal Human Resources Development Strategy - disability component	3.0
First Nations Special Education Program	95.1
Office of Learning Technologies (disability-specific projects)	0.6
Canada Pension Plan Disability, vocational rehabilitation program	3.3
INCOME SUPPORT BENEFITS	
Canada Pension Plan Disability	2,919.2
Federal workers compensation benefits [3]	125.0
Employment Insurance sickness benefits [4]	778.5
Veterans Disability Pension Programs	1,583.1
War Veterans Allowance	22.8
CAPACITY OF THE DISABILITY COMMUNITY	
Social Development Partnerships Program – Disability	15.6
INAC Assisted Living Program - disability component	0.9
HEALTH AND WELL-BEING	
Sport Canada funding for athletes with disabilities	9.9
Veterans Affairs Canada Mental Health Initiative	0.2
Population Health Fund and other health-related grants and contributions	5.8

Support for Active Living Alliance for Canadians with a Disability	0.4
FASD Initiative	5.0
Canadian Diabetes Strategy (Prevention and Promotion)	11.8
Aboriginal Diabetes Initiative	25.0
TOTAL PROGRAM EXPENDITURES	**6,114.7**
TAX MEASURES [5]	
Disability Tax Credit (including supplement for children)	460
Medical Expense Tax Credit	830
Disability Supports Deduction	20
Caregiver Credit	65
Infirm Dependant Credit	5
Child Disability Benefit	60
Refundable Medical Expense Supplement	80
TOTAL TAX MEASURES	**1,520.0**
TOTAL	**7,634.7**
PARTIALLY-TARGETED PROGRAMS	
TAX MEASURES [5]	
Age Credit [6]	1,540
Pension Income Credit [6]	440
PROGRAMS	
New Horizons for Seniors [6] (Social Development Canada)	5.0
Non-Insured Health Benefits Program (Health Canada)	767.7
First Nations and Inuit Home and Community Care Program (Health Canada)	90
Assisted living program (INAC)	81.3
Veterans treatment benefits program [7]	279.2

(1) HASI and RRAP-D amounts are for the 2004 calendar year rather than the fiscal year 2004-2005.
(2) Canada Study Grants are for the 12 months ending July 31, 2004.
(3) Includes $24.3 million in administration fees paid to Workers Compensation Boards. In addition, departments, agencies and Crown Corporations pay about $19 million directly to employees on Injury on duty leave (IODL).
(4) EI Sickness amount is for 2003-2004 as expenditures for 2004-2005 are not yet available.
(5) Tax expenditure amounts are estimates for the 2005 tax year rather than fiscal year 2004-2005. Source: Department of Finance, Tax Expenditures and Evaluations, 2004. Amounts have been adjusted to reflect changes made in Budget 2005.
(6) These are measures for seniors and are not targeted directly to seniors with disabilities.
(7) While most clients of the Veterans treatment benefits program are people with disabilities, the program provides general health-related benefits not necessarily related to disability.

APPENDIX B

PROJECTION OF POPULATION WITH DISABILITIES, CANADA 2001-2026

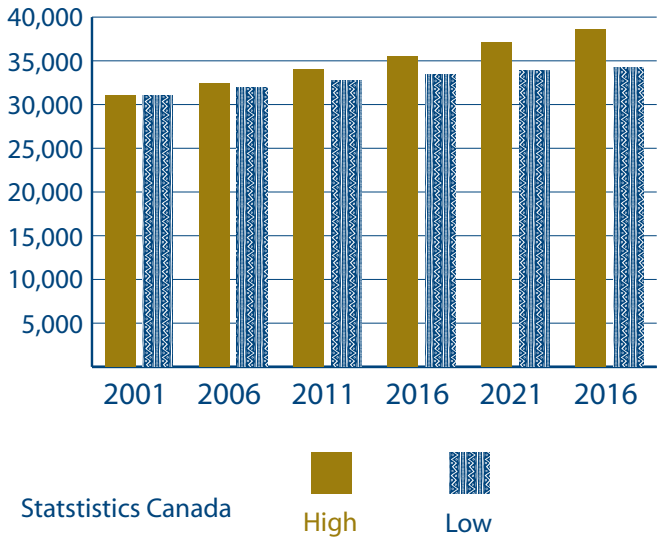
APPENDIX B shows the total number of Canadians with disabilities between 2001 and 2026. It was developed through a series of four Statistics Canada population growth projections based on varying assumptions concerning fertility, mortality, immigration and inter-provincial migration.[106] To provide a range of estimates, the disability projections shown here are based on the low and high population growth models.

The basic method is to apply the PALS 2001 disability rates to these general population projections. PALS did not survey individuals living in collective dwellings, First Nations people on reserve or in the three Territories. Since it is likely that rates of disability among these groups are higher than those of the population surveyed by PALS, the projections shown here may understate the total number of people with disabilities. The method used here does not take into account possible changes in rates, types or patterns of disability that may occur in future years. Changes in factors such as health care, the economy, the environment, educational levels and many others could impact rates of disability in the future, but the net effect of multiple factors is difficult to predict. Two studies conducted by Statistics Canada using modeling approaches to take some factors beyond population aging into account produced opposite results—one predicting a slight increase in disability rates for people of age 65 and over and the other predicting a slight decrease in rates by the year 2021. [107]

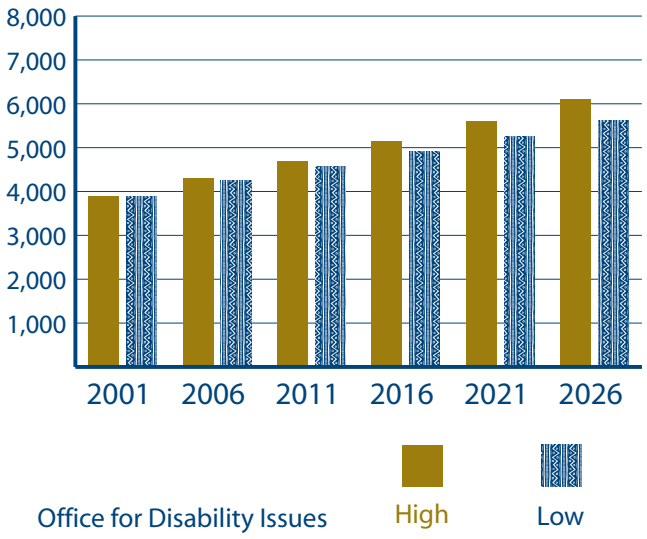
POPULATION ESTIMATES

The overall population estimates and total numbers of people with disabilities are shown in Figures B.1 and B.2. Under the low-growth scenario, the population of Canada will grow from 31 million in 2001 to 34.2 million in 2026. The total number of people with disabilities will grow from 3.9 million to 5.6 million. Under the high growth scenario the population will grow from 31 million to 38.6 million while the number

B.1 Canada total population (000s)



B.2 Canada-total population with disabilities (000s)



of people with disabilities will increase from 3.9 million to 6.1 million.

Due to the aging of the population over this period the percentage of people with disability increases between 2001 and 2026. This percentage increases from 12.6% to 16.4% in the low growth model and from 12.6% to 15.8% in the high growth projection. The disability percentage is higher in 2026 in the low-growth projection because in this scenario there are fewer people at younger ages where disability rates are lower.

CHANGING AGE COMPOSITION OF THE POPULATION

The changing overall age structure of the population from 2001 to 2026 results in a corresponding change in the age composition of the population with disabilities. Figures B.3 and B.4 show the composition in percentage terms while Figures B.5 and B.6 show the numbers of children, working-age adults and seniors with disabilities. Finally, Table B1 shows the age-sex distribution of the population in 2026.

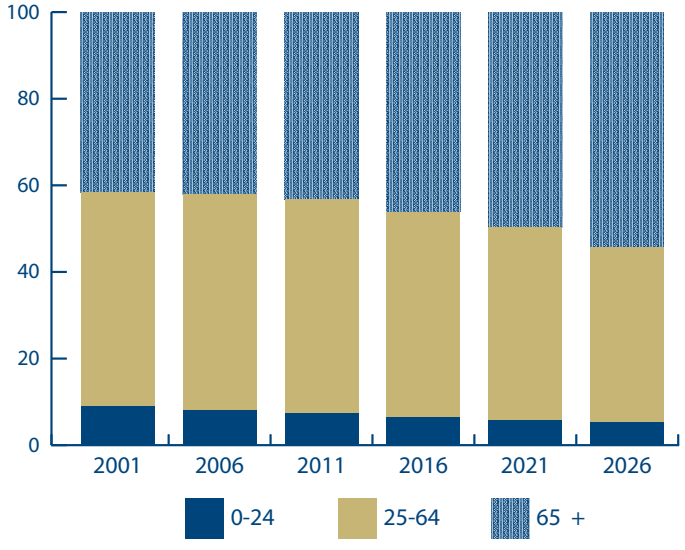
Under the low-growth scenario, seniors constitute 41.7% of the population with disabilities in 2001 rising to 46.1% in 2016 and 54.3% in 2026. Under the high-growth scenario, seniors go from 41.7% in 2001 to 46.0% in 2016 and 53.8% in 2026. This includes an unknown number of seniors living in residential care facilities.

Under the low-growth scenario, (Figure B.5) the number of children and youth 0-24 years of age with disabilities slowly decreases from 353,000 in 2001 to 292,000 in 2026. The number of adults aged 25-64 increases from 1,917,000 in 2001 to 2,344,000 in 2016 then decreases to 2,274,000 in 2026. The number of seniors with disabilities increases from 1,622,000 in 2001 to 3,046,000 in 2026.

Under the high-growth scenario,(Figure B.6) the number of children and youth 0-24 years of age with disabilities remains stable at about 353,000 until 2021 then increases to 368,000 in 2026. The number of adults aged 25-64 increases from 1,918,000 in 2001 to 2,449,000 in 2026. The number of seniors also increases from 1,622,000 in 2001 to 3,287,000 in 2026.

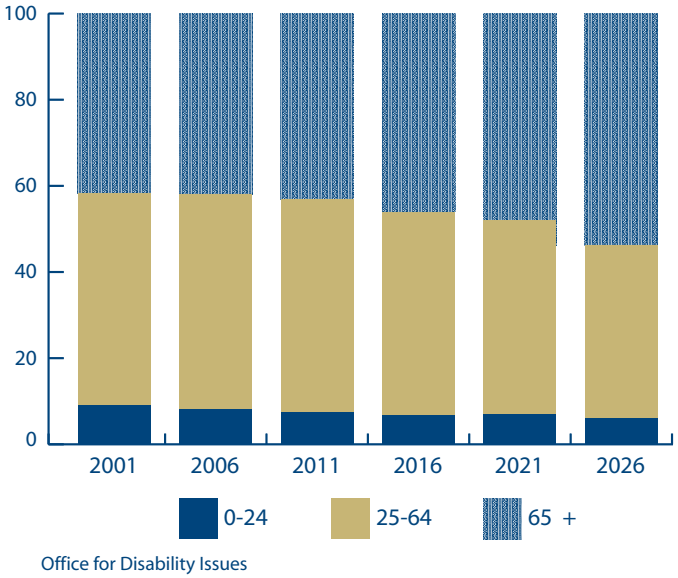
Under both the low-growth and the high-growth scenarios, women will constitute the majority of people with disabilities over the period (approximately 54% in 2026). Under the low-growth scenario in 2026, 57% of seniors with disabilities will be women and under the high growth scenario women will represent 56% of seniors with disabilities.

B.3 Composition of population with disabilities
Low growth population scenario (%)



Office for Disability Issues

B.4 Composition of population with disabilities
High growth population scenario (%)



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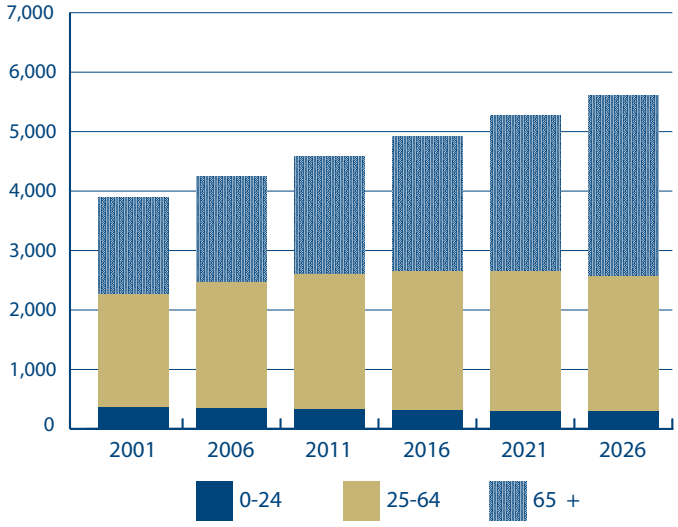
B.5 Population with disabilities by age
Low growth population scenario



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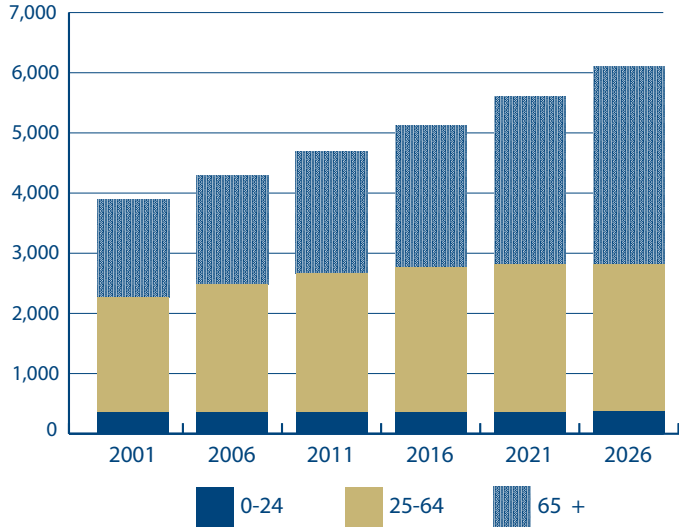
B.6 Population with disabilities by age
High growth population scenario



Office for Disability Issues

TABLE B1 Composition of population with disabilities by age and sex, Canada, 2026

High-growth Scenario (000s)						
	Total Population			Population with disabilities		
	Total	Male	Female	Total	Male	Female
0-24	10,599.8	5,440.1	5159.6	368.0	209.2	158.8
25-64	19,964.2	10,069.3	9,894.8	2,449.1	1,174.6	1,274.6
65 and over	8,029.3	3,674.1	4,355.2	3,286.8	1,439.9	1,846.9
Total Population	38,593.3	19,183.5	19,409.6	6,104.0	2,823.7	3,280.3
Low-growth Scenario (000s)						
	Total Population			Population with disabilities		
	Total	Male	Female	Total	Male	Female
0-24	8,281.8	4,250.4	4,031.4	292.1	164.7	127.4
25-64	18,422.5	9,290.2	9,132.3	2273.7	1,088.0	1,185.6
65 and over	7,486.2	3,362.9	4,123.2	3,046.0	1,305.6	1,740.4
Total Population	34,190.4	16,903.5	17,286.9	5,611.8	2,558.3	3,053.5

APPENDIX C
SELECTED GOVERNMENT OF CANADA PROGRAMS BENEFITING SENIORS WITH DISABILITIES

SENIORS WITH disabilities may benefit from the full spectrum of Government of Canada policies and programs. The following pages highlight some initiatives with particular relevance to the needs of seniors with disabilities.

■ SUPPORTING COMMUNITY PARTICIPATION OF SENIORS WITH DISABILITIES (SEE CHAPTER 3)

The following programs support the participation of seniors with disabilities in leisure activities and as community volunteers. Seniors who are still in the labour force may also benefit from employment-related programming (e.g. see Part 3 of this report).

PUBLIC HEALTH AGENCY OF CANADA

The Active Living Alliance for Canadians with a Disability (ALACD) has been funded through the *Physical Activity Contribution Program* of the Public Health Agency of Canada for fiscal year 2005-2006. The purpose of this program is to improve overall health outcomes and reduce health disparities for Canadians affected by intellectual, mobility, sensory or mental health limitations. This Strategy follows the same framework as the Integrated Pan-Canadian Healthy Living Strategy led by the Public Health Agency of Canada (PHAC) and provides interventions to bridge the gap for Canadians with a disability, including seniors with disabilities. This project provides information and messaging regarding the value of physical activity/quality of life for all Canadians with disabilities, to foster attitude and behaviour changes among people with disabilities and service providers, to build capacity, and to strengthen provincial/territorial and community partnerships. (For more details see the section on Promoting the Health of Seniors in this Appendix).

SOCIAL DEVELOPMENT CANADA

Social Development Canada's *New Horizons for Seniors* program is a grant-based program that enables seniors' social participation, active living and contribution to their community. The program objectives are to encourage seniors to share their skills, experience and wisdom in support of their community through, for example, voluntarism, mentorship and civic leadership, and to reduce the risk of social isolation of seniors, by creating opportunities for increased association, belonging and life skills development of seniors.

Municipal governments, voluntary, social economy and non-profit sector organizations as well as band/tribal councils and other Aboriginal organizations are eligible to apply for funding. Funded projects must be led and implemented by seniors, be non-profit in nature, and address provincial/territorial priorities. Funding is available for up to 12 months.

■ ADDRESSING AVAILABILITY OF DISABILITY SUPPORTS FOR SENIORS WITH DISABILITIES (SEE CHAPTER 4)

The Government of Canada is committed to collaborating with provincial and territorial

governments to help provide programs and services that assist people with disabilities overcome access barriers to disability supports. Some disability support areas are under the direct responsibility of the Government of Canada and are related to the needs of seniors with disabilities such as specific industry regulations, supports for aging First Nations, Métis and Inuit peoples and supports for Veterans.

The following are profiles of selected Government of Canada initiatives that are helping to make disability supports better and more accessible to seniors with disabilities.

FINANCE CANADA/CANADA REVENUE AGENCY

Seniors with disabilities may benefit from the *medical expense tax credit* (METC) which recognizes the effect of above-average disability-related or medical expenses on an individual's ability to pay tax. Some may also claim the *disability supports deduction* which provides tax relief for the cost of disability supports incurred for the purposes of employment or education. Additional details are described in Chapter 8.

CANADA MORTGAGE AND HOUSING CORPORATION

The Canada Mortgage and Housing Corporation (CMHC) offers several programs to help address the housing needs of Canadians including seniors with disabilities. CMHC also sponsors research and undertakes information transfer initiatives that are helping to meet the current and future housing needs of seniors.

Home Adaptations for Seniors Independence (HASI) helps homeowners and landlords pay for minor home adaptations to extend the time seniors with low-income can live in their homes independently. Homeowners and landlords may qualify for assistance as long as the occupant of the dwelling where the adaptations will be made is 65 years of age or over, has difficulty with daily living activities brought on by aging, has a total household income that is at or below a specified limit for the area and the dwelling unit is a permanent residence. Evaluation of HASI indicates that 80% of HASI clients have found that their lives have been made more comfortable, safer, and increased their ability to live independently as a result of the adaptations they have made in their homes. The majority also felt that if they had not made the adaptation to their home they would have had to move. Also, a number of HASI clients (40%) would not have made the adaptations without the HASI program.[108]

The *Residential Rehabilitation Assistance Program—Secondary/Garden Suite* was announced in May 2005. This new program provides funding to help seniors to continue living longer in their own home or move closer to their family. The program funds the creation of secondary or garden rental suites—an affordable rental housing option for low-income seniors and adults with a disability. Eligible clients are homeowners, private entrepreneurs, and First Nations owning residential properties who could create a bona fide affordable self-contained rental accommodation. Eligibility is limited to existing family housing residential properties.

The *Residential Rehabilitation Assistance Program for Persons with Disabilities* (RRAP-D) offers financial assistance to homeowners and landlords to undertake accessibility work to modify dwellings occupied or intended for occupancy by low-income seniors and people with disabilities. For eligible homeowners and landlords, assistance is in the form of a forgivable loan for 100% of the cost of the necessary modifications up to the available value for the area. CMHC has sponsored an evaluation of its RRAP programs including RRAP-D covering the period of 1995-2001 to determine how effectively these programs are meeting their objectives.[109] The evaluation indicates that RRAP-D is having a significant positive impact on the accessibility of units modified under the program and on the ability of persons with disabilities to carry out daily living activities.

FlexHousing™, developed by CMHC in 1995, is a practical and innovative approach to

designing and building housing that allows residents to convert space to meet their ever-changing needs. Based on the principles of adaptability, accessibility, affordability and healthy housing, FlexHousing responds to the needs of today's families and supports independent living for people with disabilities and seniors. FlexHousing appeals to individuals with disabilities and those who would like to age in place because expensive renovations are not needed to make the housing more accessible when aging decreases mobility or vision.

Housing Options for People with Dementia is a guide that aims to increase awareness of new housing options for people with dementia and to encourage the development of more community-based solutions. This guide describes a range of housing options, support services, management principles, and environmental design to meet the housing needs of people with dementia.

Research is an important part of CMHC's commitment to helping Canadians and the housing industry. As part of its research and information transfer mandate, CMHC has undertaken, sponsored or fostered a broad range of research and information transfer initiatives related to seniors housing which are designed to encourage innovation in a variety of areas including: community planning; the development of new types of housing options; new financing options and types of tenure to improve housing affordability; the implementation of innovative design concepts and the use of new technology and home adaptations to improve comfort, safety and security.

As part of the National Housing Research Committee sponsored by CMHC, the Seniors Working Group meets biannually to share information of common interest on seniors housing research, establish priorities for housing research issues and undertake activities that address them and identify and develop opportunities for collaborative housing research among its members.

CANADIAN HUMAN RIGHTS COMMISSION

Increasingly, the Canadian Human Rights Commission (CHRC) attempts to resolve human rights issues through research, studies and dialogue. Following reports that making phone calls to government departments are often difficult for those who are deaf, deafened and hard of hearing, or who have a speech impediment, the CHRC initiated a study of the availability of services for hearing impaired people with a goal of fostering equal access for all Canadians.

CANADIAN TRANSPORTATION AGENCY

When seniors with disabilities encounter barriers to their use of the transportation system that relate to accessibility they can ask the Canadian Transportation Agency for help. The Agency offers several services to assist travellers in coping with obstacles on a case-by-case basis by mediating or adjudicating complaints, and on a systemic basis by developing regulations, codes of practice and standards concerning the level of accessibility in modes of transportation under federal jurisdiction. The Canadian Transportation Agency requires that mobility devices such as canes, walking sticks, wheelchairs, scooters and walkers used for balance be carried free of charge as priority baggage and if space permits in the cabin of passenger aircraft. Transportation Service providers are required to train staff to provide assistance in moving through a transportation terminal as well as in boarding and exiting a transportation vehicle including guiding and communication techniques.

The Canadian Transportation Agency's work on the Code of Practice to remove barriers in transportation terminals in the federal transportation network will be of particular benefit to seniors. These measures, when adopted, will make it easier for seniors with disabilities to negotiate transportation terminals and to benefit from their service amenities when travelling. Being considered for inclusion in the Code: providing rest areas in long corridors for people who have difficulty walking long

distances, providing an alternative for people who have difficulty standing in line and avoiding potential hazards and surfaces that could cause falls. A first draft of the Code was presented to the Agency's Accessibility Advisory Committee in the fall of 2005. The projected release date of the Code of Practice is 2007.

TRANSPORT CANADA

In its *Straight Ahead* policy statement[110] released in February 2003, Transport Canada committed to work with the community of people with disabilities, senior citizens and the transportation industry in order to develop a long-term, multi-modal federal strategy for enhancing the accessibility of the national transportation system. The National Workshop for Driver Rehabilitation Specialists, sponsored by the Transportation Development Center of Transport Canada in 2002 and 2004, provided a unique opportunity for driver rehabilitation specialists to assess the abilities of seniors and people with disabilities in driving and obtaining a driver's license as well as prescribing adaptive automotive aids required and any specific vehicle modifications. This event allows practitioners, vehicle modifiers, equipment manufacturers and researchers in the field to meet and exchange experiences and information.

Transport Canada also funds a research project on In-Vehicle Intelligent Transportation System (ITS) Countermeasures to Improve Older Driver Intersection Performance. The long-term objective of this research is to bring into the public domain a comprehensive set of ergonomic guidelines for ITS equipment and ITS in-vehicle countermeasures suitable for seniors and those with disabilities to improve their intersection performance and reduce intersection crashes.

PUBLIC HEALTH AGENCY OF CANADA

The Division of Aging and Seniors engages in a wide variety of public awareness and health promotion activities and produces educational materials that support seniors with disabilities, particularly in the area of assistive devices and technology.

VETERANS AFFAIRS CANADA

Veterans Affairs Canada's *Gerontological Advisory Council* advises the Department on policies, programs, services and trends impacting Canada's aging veterans. Members of the Council also participate in Departmental educational symposiums that provide staff, other health care professionals and the general public with a forum to share information about the opportunities and challenges associated with caring for Veterans, their families and other Canadian seniors. Since its inception, the Council has provided the Department with guidance on a number of pressing concerns, including caregiver initiatives, alternative housing trends for Veterans, long term care, health promotion and education, and departmental research.

The *Veterans Independence Program* (VIP) is a national home care program, first introduced by Veterans Affairs Canada as the "Ageing Veterans Program" in 1981. The objective of the Program is to help Veterans remain healthy and independent in their own homes. It is based on the premise that clients will take whatever responsibility they can for their own care, and that they will use VIP services, along with their own resources, to achieve as much independence as possible. The services Veterans receive depend on their particular circumstances and health needs, and may include home care services (grounds maintenance, housekeeping, personal care services, access to nutrition services, health and support services provided by health professionals), ambulatory health care, social transportation, nursing home care and home adaptations.

Up until September 1, 1990, VIP services were provided only to eligible Veterans. However, recognizing that a sudden withdrawal of these services at the time of the Veteran's death could place undue hardship on the surviving spouse, VAC modified the program to allow for a one-year continuation to the surviving spouse of

housekeeping and/or grounds maintenance services. A series of additional program enhancements between 2003 and 2005 have resulted in a continuation of VIP housekeeping and/or grounds maintenance services being granted to eligible primary caregivers (including spouses and common-law partners) for as long as there is a health need for the services or until he or she is admitted to a health care facility.

On September 10, 2004, the Minister of Veterans Affairs Canada, in partnership with the Government of Ontario, announced a two-year *Continuing Care Research Project*. This is a collaborative initiative between Veterans Affairs Canada (VAC) and the Ontario Senior's Secretariat and is endorsed by the Canadian Seniors Partnership. A study of the Veterans Independence Program will compare the cost and outcomes of providing home care, supportive housing and residential care. A second study will evaluate the impact of the "At Home Pilot Project". The results of these studies will provide Canadians with a better understanding of the support seniors need to age with dignity and to make their own decisions about the care they need.[111]

Seniors Canada On-line (www.seniors.gc.ca) offers key links to seniors-related information from the Government of Canada, Provincial, Territorial and community web sites. It contains content of value to seniors as well as their family members, caregivers and service providers. VAC has partnered with the Province of Ontario and four communities, to create the *Collaborative Seniors Portal Network* (CSPN). The goal of the CSPN is to ensure that no matter what Web site a senior prefers to use, if that site is a member of the CSPN, information from all levels of government as well as non-government organizations will be displayed.

■ PROMOTING THE HEALTH OF SENIORS WITH DISABILITIES (SEE CHAPTER 5)

This section profiles selected Government of Canada initiatives that are contributing to improved health and well-being of seniors with disabilities.

HEALTH CANADA AND THE PUBLIC HEALTH AGENCY OF CANADA

Each year in Canada, more than three-quarters of deaths result from four groups of non-communicable diseases: cardiovascular, cancer, diabetes, and respiratory. The Government of Canada acknowledges the importance of efforts to address prevention, promotion and public health, and the sustainability of the health system.

The *Integrated Pan-Canadian Healthy Living Strategy*, an intersectoral initiative, was approved by Federal/Provincial/Territorial Ministers of Health at their annual meeting in October 2005. The Integrated Strategy on Healthy Living and Chronic Disease, launched by the Government of Canada in October 2005, forms the basis of the government's federal contribution to the *Integrated Pan-Canadian Healthy Living Strategy.* Both are

aimed at improving overall health outcomes and reducing health disparities by addressing common preventable risk factors - namely physical inactivity and unhealthy eating – to prevent chronic disease.

On behalf of the federal government and 13 partner departments, the Public Health Agency of Canada coordinates the *Family Violence Initiative* (FVI). With the long-term goal of reducing the occurrence of family violence in Canada, the Government of Canada provides the FVI with $7 million in permanent annual funding. This allocation supports and complements activities across seven departments and agencies: Public Health Agency of Canada, Canada Mortgage and Housing Corporation, Justice Canada, RCMP, Canadian Heritage, Status of Women Canada,

and Statistics Canada. The FVI promotes public awareness of the risk factors for family violence and the need for public involvement in responding to it; strengthens the ability of the criminal justice, housing, and health systems to respond; and supports data collection, research and evaluation efforts to identify effective interventions.

As part of the FVI, the Public Health Agency operates the *National Clearinghouse on Family Violence*. The Clearinghouse is a national resource for Canadians who are seeking knowledge about violence in relationships of kinship, intimacy, dependency or trust. The Clearinghouse collects and develops information on family violence and maintains a collection of publications on family violence issues. Among the many publications distributed by the Clearinghouse, several address the abuse of people with disabilities and seniors.

From 2000 to 2004, Health Canada and Veterans Affairs Canada collaborated on an initiative to prevent falls among seniors and veterans, a serious health issue often leading to long-term disability. The *Falls Prevention Initiative* provided $10 million in funding over four years to community-based projects whose primary objective was to promote the independence and quality of life of veterans and seniors by preventing the number and reducing the severity of falls. The target populations for the initiative were community-dwelling veterans, seniors and their caregivers.[112]

The Public Health Agency solicited new project proposals in 2004 for the *Population Health Fund*. Eleven projects related to seniors' health were approved for funding. The seniors' health priorities for this solicitation were: seniors' mental health; safe and supportive environments (including the specific areas of disability, assistive devices/technology; abuse and neglect; falls prevention); and healthy aging. Proposals were required to address the following issues: enhancing awareness and knowledge of the barriers and issues affecting seniors with disabilities, including seniors with lifelong disabilities and to develop and strengthen collaboration and partnerships among disability and seniors' organizations to acknowledge and address the needs of disabled seniors.

VETERANS AFFAIRS CANADA

In recent years, War Service Veterans who suffer from a moderate to severe disability related to their service have been provided with broadened access to VAC's health care benefits, including Treatment (prescription drugs, special equipment, vision care, audio (hearing) care, and others), Veterans Independence Program services (home care, home adaptations, transportation, ambulatory health care and nursing home care) and Long-Term Care. Veterans in receipt of a pension are no longer limited to receiving health benefits required solely for their service-related disabilities; rather, they are eligible to receive benefits based on their needs. This broadened access recognizes the increasing difficulty of distinguishing between the effects of a disability related to their service from the disability resulting from the natural aging process.

Veterans Affairs participates in the Alzheimer Society of Canada's *Safely Home— Alzheimer Wandering Registry* through a service contract which allows the Alzheimer Society to process applications without the standard fee from those Veterans who indicate that they are currently receiving benefits from VAC. VAC then reimburses the Alzheimer Society the one-time standard fee of twenty-five dollars. The Registry is a nationwide program assisting police in finding people who are lost and safely returning them home. When a person registered with the Program is either reported missing or found wandering, an identification bracelet advises the finder to call the local police. The unique ID number on the bracelet allows police to access the Program's database to quickly determine the person's name, address and the phone number of family or friends to be contacted.

Veterans Affairs Canada operates *Ste-Anne's Hospital* to meet the physical, psychological and social needs of the Veterans who stay there or

who receive services on an out-patient basis. While meeting the needs of its own clients, Ste-Anne's also develops resources that may be of value to Veterans elsewhere and to other seniors.

■ ADDRESSING INCOME NEEDS OF SENIORS WITH DISABILITIES (SEE CHAPTER 6)

The following are profiles of selected Government of Canada initiatives that are helping many seniors with disabilities meet their income needs.

FINANCE CANADA/CANADA REVENUE AGENCY

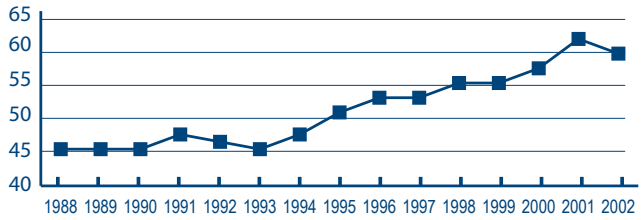
The *disability tax credit* (DTC) provides tax relief to individuals who, due to the effects of a severe and prolonged mental or physical impairment, are markedly restricted in their ability to perform a basic activity of daily living as certified by a qualified health practitioner, or would be markedly restricted were it not for extensive therapy to sustain a vital function. The basic activities of daily living are: walking; feeding or dressing oneself; perceiving, thinking and remembering; speaking; hearing; and eliminating bodily waste.

The DTC recognizes the impact of non-itemizable disability-related costs on an individual's ability to pay tax. For 2005, the credit is 16 percent of $6,596, which provides a federal tax reduction of up to $1,055. This credit can be transferred to a supporting spouse, parent, grandparent, child, grandchild, brother, sister, aunt, uncle, nephew or niece of the individual. The credit amount is fully indexed to inflation.

As a result of the recommendations of the Technical Advisory Committee on Tax Measures for Persons with Disabilities, Budget 2005 proposed to extend eligibility for the DTC to individuals who face multiple restrictions that together have a substantial impact on their everyday lives and amend the DTC to ensure that more individuals requiring extensive life-sustaining therapy on an ongoing basis are eligible, and clarify other parts of the DTC eligibility criteria, including the provisions dealing with impairments in mental function.

Following the trend of population aging, the proportion of DTC self-claimants who are seniors has increased in recent years. More than half of individuals who now claim the DTC for themselves are seniors.

C.1 Percentage of disability tax credit self-claimants who are seniors 1988-2002 (%)



Department of Finance

Tax credits and deductions for persons with disabilities and their caregivers recognize that these individuals face extra disability-related expenses that reduce their ability to pay tax. This function of recognizing costs in the tax system helps to level the playing field for people with disabilities and their caregivers. However, it is distinct from the income support offered by programs such as Old Age Security described below.

The *age credit* provides tax relief to low- and middle-income seniors. It provides a credit of 16 per cent on an amount of $3,979 to Canadians age 65 and over, for a maximum federal tax reduction of $637 for 2005. Unused portions of this credit can be transferred to a spouse or common-law partner. The credit amount and the income threshold are fully indexed to inflation.

The *pension income credit* was introduced to provide additional protection against inflation for retirement income. It provides a credit of 16 percent on the first $1,000 of pension income, for a maximum federal tax reduction of $160 for 2005. Unused portions of this credit can be transferred to a spouse.

SOCIAL DEVELOPMENT CANADA

The foundation of Canada's retirement income system is the *Old Age Security* (OAS). The OAS includes a basic pension that goes to almost all people 65 or older who have lived in Canada for a certain time. The *Guaranteed Income Supplement* (GIS) is an additional monthly benefit for low-income OAS pensioners. The allowance provides a monthly benefit to low-income people between the ages of 60 and 64. It is available to the spouses or common-law partners of OAS pensioners and survivors to help bridge the gap until they become entitled to receive OAS at 65. Generally, you receive a full OAS pension if you lived in Canada for at least 40 years after 18 years of age.

Budget 2005 announced that low-income senior citizens will see an increase in the maximum monthly GIS of $36 for single seniors and $58 for couples. Half the increase will go into effect on January 1, 2006, with the remainder coming one year later. It is estimated that 1.6 million seniors will benefit from the change.

The *Canada Pension Plan* (CPP) is the second level of Canada's retirement income system. It has been in effect since 1966, and is a national plan based on contributions from workers and employers in Canada. It is best known for its retirement pension, but also provides survivor, death and disability benefits to CPP contributors and their families.

The CPP Disability program is the largest long-term disability program in Canada. It is designed to replace a portion of income to CPP contributors who are unable to work because of a severe long-term disability. Benefits are paid monthly to eligible applicants and their dependent children.[113]

It is not possible to receive a CPP disability benefit and a CPP retirement pension at the same time. However, for people with disabilities receiving the CPP disability benefit, this benefit will be automatically be converted to a CPP retirement pension the month after their 65th birthday.

The CPP operates throughout Canada, although the province of Québec has its own similar program, the Québec Pension Plan. The Canada Pension Plan and the Québec Pension Plan work together to ensure that all contributors are protected.

VETERANS AFFAIRS CANADA

Veterans Affairs Canada (VAC) provides a disability pension for persons who have a medical disability related to their service as a War Service Veteran; a Canadian Forces (CF) Veteran; or a Merchant Navy Veteran of the First; or Second World War or the Korean War; a current or former member of the Regular or Reserve Force; or a civilian who served in close support of the Armed Forces during wartime. Veterans disability pensions provide compensation for disability suffered as a result of service and are not considered as income for tax purposes.

In general, a disability pension is a monthly amount, the rate of which is tied to the degree of pensionable disability and the connection of the disability to service (e.g. is the cause of disability fully or partially connected to service). Currently the monthly rate varies from approximately $100 to $2,000 for a single Veteran. Additional pension is paid if the Veteran has a spouse and also if there are dependent children.

An additional monthly allowance is provided to pensioners who are exceptionally incapacitated in whole or in part by their pensioned disability. The amount of the allowance is based on the extent of the helplessness, pain, loss of enjoyment of life and shortened life expectancy of the pensioner. An Attendance Allowance is also available to a pensioner who has a disability assessed at 1% or more and/or is receiving prisoner of war compensation. The pensioner must also be totally disabled and in need of attendance due to his or her physical or mental state. The amount is based on the degree of attendance needed in the day-to-day personal care of the pensioner.

VAC currently provides disability pensions to 166,000 Canadians—many of them being seniors—for a total of $1.57 billion.

War Veterans Allowance

The War Veterans Allowance (WVA) Program provides an income support safety net to low-income Veterans who served during either World War I or II, or the Korean War, with a regular monthly income to help them meet their basic needs. The Program is based on income, family status, number of dependants, and residence. Survivors may also qualify if the deceased Veteran had the required war service.

The WVA Program becomes a "top up" payment after these same persons become beneficiaries under the *Old Age Security Act* administered by Social Development Canada. Recent changes to the *Old Age Security Act* increasing the applicable rates for Canadian seniors will also be enjoyed by recipients of the WVA benefit. The WVA Program also serves as a "gateway" to other programs and benefits, such as health care benefits, including the Veterans Independence Program.

VAC currently provides WVA to 9,645 clients, all of whom are seniors, for an annual total of $22.4 million.

■ ADDRESSING THE NEEDS OF FIRST NATIONS, MÉTIS AND INUIT ELDERS WITH DISABILITIES (SEE CHAPTER 7)

CANADA MORTGAGE AND HOUSING CORPORATION

The Residential Rehabilitation Program for Persons with Disabilities (RRAP-D), RRAP-Secondary/Garden Suite and Home Adaptations for Seniors Independence (HASI) are financial assistance programs available to on-reserve Aboriginal Canadians with disabilities and elders. The eligibility criteria and program limits are the same.

(See the description of these initiatives in the Disability Supports section of this appendix.)

HEALTH CANADA

The *Aboriginal Diabetes Initiative* is designed to provide a more comprehensive, collaborative and integrated approach to decreasing diabetes and its complications among Aboriginal peoples. It has been developed in partnership with Aboriginal people. Programs emphasize holistic approaches to health promotion, diabetes prevention, and diabetes screening and care, and strive to be culturally appropriate. Programs are based in the community, and Aboriginal people are involved in all stages of development, implementation and program maintenance.

To date, the *Aboriginal Diabetes Initiative* has created the opportunity for diabetes programming in more than 600 First Nations and Inuit communities and has funded 40 primary prevention programs serving Métis, off-reserve Aboriginal and urban Inuit stakeholders. In Budget 2005, the federal government committed $190 million over five years to build and enhance diabetes programming. This investment will be used to promote healthy lifestyles and to increase access to diagnostic and complications screening and care programs.

First Nations and Inuit Home and Community Care Program

The need for home-care services among First Nations and Inuit communities was first identified 15 years ago, based on the fact that:

- The disability and injury rates in Aboriginal communities are much higher than in the general population.
- The Aboriginal population is expected to double over the next two decades, and growing numbers of First Nations elders are returning to their home communities.

The *First Nations and Inuit Home and Community Care Program*, funded by Health Canada, provides basic home and community care services that meet the unique health and social needs of First Nations people and Inuit.

The program's coordinated services allow people with disabilities, people with chronic or acute illnesses and elders to receive care in their own home or community. The program's guiding principles include respecting First Nations and Inuit approaches to healing and wellness. They also include community-focused planning, as well as supportive family and community involvement.

The support services offered depend on the availability of resources to respond to the needs identified in the planning phase. For communities that already have certain services, the program offers to augment them by building on existing investments in health and community-based services. Funding for the program was $90 million in both 2003-2004 and 2004-2005.

The First Nations and Inuit Home and Community Care Program has forged

links with other Health Canada programs, other federal programs, other programs at different levels of government and other organizations, both government funded and non-government. The program was also designed and launched collaboratively, with national, regional, Provincial, Territorial and community input from Health Canada, Indian and Northern Affairs Canada, and First Nations people and Inuit.

Collaboration with First Nation and Inuit communities is vital to the program—to its performance measurement strategy, to its ongoing operation and to its policy development activities, which strive to address gaps in care. Performance reporting and accountability for results occurs through the parliamentary reporting process, using the departmental performance report and the Report on Plans and Priorities.

Non-Insured Health Benefits Program for First Nations and Inuit people

The *Non-Insured Health Benefits* (NIHB) Program of Health Canada provides to eligible First Nations people and Inuit a limited range of medically necessary health-related goods and services not covered by other provincial, territorial or federal programs or private plans. The objective of the Program is to assist eligible First Nations and Inuit to attain health levels comparable to other Canadians and in a way that is suitable to their unique health needs.

The health benefits funded under the NIHB Program include medical supplies and equipment, prescription drugs and over-the-counter medication, medical transportation, vision care, dental care and crisis intervention mental health counseling. The NIHB Program also funds provincial health premiums for eligible clients in Alberta and British Columbia. Individuals should access benefits available to them under other government programs or private plans prior to accessing the NIHB Program.

INDIAN AND NORTHERN AFFAIRS

Indian and Northern Affairs' *Income Assistance* program provides funding for First Nations communities to administer income assistance activities with the objective of providing all eligible individuals and families on-reserve with the means to meet the basic needs of food, clothing and shelter. Indian and Northern Affairs must adopt the rates and eligibility requirements of the host provincial or territorial income assistance program and, following those criteria, may also fund for special needs, such as dietary requirements, which may not be included as items of basic needs.

The *Assisted Living Program* supports First Nations people who have functional limitations due to age, health problems or disability, to maintain their independence, to maximize their level of functioning, and to live in conditions of health and safety. The Assisted Living Program provides non-medical social support programs that meet the special needs of First Nations individuals with functional limitations at standards reasonably comparable to the reference province or territory of residence, regardless of age. These social supports allow people to remain at home and in their community whenever possible. When providing services at home is not feasible and institutional care is needed, the Assisted Living program may fund non-medical care for

people in designated facilities, requiring some personal care on a 24-hour basis.

The program is divided into three components: In-Home Care, Institutional Care, and Foster Care. The In-Home Care component provides financial assistance for non-medical personal care services such as meal programs and preparation, attendant care, laundry, ironing, and minor home maintenance. The Institutional Care component reimburses some expenses for social care in designated facilities. The Foster Care component provides funding for supervision and care in a family setting to individuals who do not require 24-hour care but are unable to live on their own.

The Assisted Living Program works closely with Health Canada's First Nations and Inuit Home and Community Care program which provides core elements of a home care program, building on Indian and Northern Affairs' in-home support services, for seniors, people with disabilities, the chronically ill, and those requiring short-term acute care replacement services..

APPENDIX D
SOURCES OF DATA ABOUT ABORIGINAL PEOPLE WITH DISABILITIES

THE 2001 Census, conducted by Statistics Canada, provides information including Aboriginal identity; demographic and socio-economic data; and whether the respondent has a disability. The Census includes two questions used to determine disability status: (a) difficulty with hearing, seeing, communicating, walking, climbing stairs, bending, learning or doing any similar activity and (b) presence of a physical or mental condition that reduces the amount or kind of activity at home, school, work or in other activities.

The second edition of the Aboriginal Peoples Survey (APS) was conducted by Statistics Canada in 2001, in partnership with national Aboriginal organizations. APS is a post-censal survey, meaning that respondents were selected based upon their responses to the 2001 Census. The APS included those who said they identified as an Aboriginal person, and/or had Aboriginal ancestry, and/or First Nations membership and/or registration under the *Indian Act*. The APS also includes the same two questions used in the Census to determine the presence of disability.

The primary objective of the 2001 APS was to provide data on the social and economic conditions of Aboriginal people in Canada. Unfortunately, a number of First Nations communities chose not to participate in the APS, meaning that findings for "Indian reserves" are not necessarily representative of the entire population in First Nations communities. As well, residents of collective dwellings are excluded from the survey.

The third statistical source is the First Nations and Inuit Regional Health Survey (FNIRHS) conducted in 1996-1997 by the Assembly of First Nations. The FNIRHS survey provided, for the first time, a detailed picture of the health of Labrador Inuit and First Nations people living in First Nations communities across Canada.

The First Nations Longitudinal Regional Health Survey (RHS) was conducted in 2002-2003 by the First Nations Center at the National Aboriginal Health Organization. Like the FNIRHS, the 2002-2003 RHS is expected to be a rich source of data about health and related issues for First Nations people, however, it does not include any Inuit communities. Results from the RHS have only recently started to become available and the Government is pleased to include some information from this new source.

Both the FNIRHS and the RHS employ similar questions to identify people with disabilities as those used in the Census and APS. However, the questions are not identical and other differences in survey methodologies mean that comparisons across surveys must be undertaken with caution. [114]

APPENDIX E

■ ACRONYMS USED IN THIS REPORT

ALACD	Active Living Alliance for Canadians with a Disability
APS	Aboriginal Peoplfdres Survey
CCHS	Canadian Community Health Survey
CCSD	Canadian Council on Social Development
CDS	Canadian Diabetes Strategy
CSPN	Collaborative Seniors Portal Network
CF	Canadian Forces
CHRC	Canadian Human Rights Commission
CMHC	Canada Mortgage and Housing Corporation
CNIB	Canadian National Institute for the Blind
CPP	Canada Pension Plan
CPPD	Canada Pension Plan, disability component
CRA	Canada Revenue Agency
CSA	Canadian Standards Association
DTC	Disability Tax Credit
EAPD	Employability Assistance for Persons with Disabilities
EI	Employment Insurance
FASD	Fetal Alcohol Spectrum Disorder
FNIRHS	First Nations and Inuit Regional Health Survey
FVI	Family Violence Initiative
GIS	Guaranteed Income Supplement
HASI	Home Adaptations for Seniors Independence Program
HRSDC	Human Resources and Skills Development Canada
HUI™	Health Utility Index
ICF	International Classification of Functioning, Disability and Health
INAC	Indian and Northern Affairs Canada
ITS	In-Vehicle Intelligent Transportation System
LICO	Low-Income Cut-Off
LMAPD	Labour Market Agreements for Persons with Disabilities
METC	Medical Expense Tax Credit
MOS	Medical Outcomes Study
NACA	National Advisory Council on Aging
NIHB	Non-Insured Health Benefits
NSGVP	National Survey of Giving, Volunteering and Participating
OAS	Old Age Security
ODI	Office for Disability Issues
OF	Opportunities Fund program
PALS	Participation and Activity Limitation Survey
PHAC	Public Health Agency of Canada
RCMP	Royal Canadian Mounted Police
RESP	Registered Education Savings Plan
RHS	First Nations Longitudinal Regional Health Survey
RRAP-D	Residential Rehabilitation Assistance Program for Persons with Disabilities
SDC	Social Development Canada
SDPP/D	Social Development Partnerships Program's, disability component
SLID	Survey of Labour and Income Dynamics
UN	United Nations
VAC	Veterans Affairs Canada
VIP	Veterans Independence Program
WHO	World Health Organization
WVA	War Veterans Allowance

APPENDIX F

■ CONTRIBUTING DEPARTMENTS AND AGENCIES

The departments and agencies listed below contributed information to this report and assisted with reviews and comments. Their participation is gratefully acknowledged.

- Agriculture and Agri-Food Canada
- Canada Mortgage and Housing Corporation
- Canada Revenue Agency
- Canadian Heritage
- Canadian Human Rights Commission
- Canadian Institute for Health Information
- Canadian Transportation Agency
- Elections Canada
- Environment Canada
- Finance Canada
- Health Canada
- Human Resources and Skills Development Canada
- Indian and Northern Affairs Canada
- Industry Canada
- Justice Canada
- Library and Archives Canada
- Privy Council Office
- Public Health Agency of Canada
- Public Service Commission of Canada
- Public Service Human Resources Management Agency of Canada
- Public Works and Government Services Canada
- Social Development Canada
- Social Sciences and Humanities Research Council of Canada
- Statistics Canada
- Status of Women Canada
- Transport Canada
- Treasury Board of Canada Secretariat
- Veterans Affairs Canada

ENDNOTES

1 The first and third sections of the report present a variety of statistical data and results of qualitative research to illustrate the issues faced by Canadians with disabilities. Information obtained from published work is referenced by the appropriate citations. Much of the information presented, however, is based on previously unpublished analyses by Social Development Canada.

2 Auger, J. A. & Tedford-Litle, D. (2002).*From the inside looking out: Competing ideas about growing old.* Halifax: Fernwood Publishing. p. 111

3 Minichiello, V., Browne, J., & Kendig, H. (2000). Perceptions and consequences of ageism: Views of older people. *Ageing & Society, 20 (3)*, 253-278.

4 Available at www.archlegalclinic.ca/index.asp

5 All names that appear in this report are either pseudonyms assigned to protect the privacy of the individual, or individuals' own names, as they appear with permission in previously-published work.

6 Metcalfe, M. (2005). *Anecdotes on Aging: Real life perspectives*. Ottawa: Author.

7 *Defining Disability: A Complex Issue* discusses the definition of disability found in the *Employment Equity Act* found at www.sdc.gc.ca/asp/gateway.asp?hr=en/hip/odi/documents/Definitions/Definitions000.shtml&hs=pyp *In Unison* is available at http://socialunion.gc.ca/pwd_e.html. The Supreme Court's decisions on Mercier and Granovsky are described in the Ontario Human Rights Commission *Policy and Guidelines on Disability and the Duty to Accommodate* found at www.ohrc.on.ca/english/publications/index.shtml#policy.

8 This approach adopted by Statistics Canada since its first national disability survey in 1986 is based on recommendations of the World Health Organization. Many countries have adopted similar survey techniques.

9 In addition to seniors living in the community we can estimate the total number of seniors with disabilities by adding the number of seniors living in residential care. The Statistics Canada Residential Care Facilities Survey provides an estimate of the number of individuals living in such Canadian facilities. Using this survey, we can estimate that in 2001 there were about 176,000 Canadian seniors with disabilities living in facilities providing residential care. The total number of Canadian seniors with disabilities in 2001 can therefore be estimated as approximately 1,628,000 individuals.

10 Statistics Canada has prepared various population projections including low-growth, medium-growth and two high-growth scenarios. Figure 4.3 was developed by applying PALS disability rates to the low-growth scenario. This scenario results in higher percentages of persons with disabilities than the high growth scenario but smaller total population numbers. For more details on this projection of persons with disabilities as well as one based on a high-growth population projection, see Appendix B. See Statistics Canada publication *Population Projections for Canada Provinces and Territories 2000-2026* (Cat 91-520) for full details on the base population projection.

11 Bergman, H. et al. (2003). The *Canadian Initiative on Frailty and Aging.* Available at www.frail-fragile.ca/docs/Background-CIFA.pdf

12 Victorian Accommodation & Ageing Committee (2002). *Towards a Positive Third Age for People with Disabilities.* Available at www.acrod.org.au/divisions/vic/thirdage.doc

13 Metcalfe, M. (2005). *Anecdotes on Aging: Real life perspectives*. Ottawa: Author.

14 World Health Organization (2002). *Active Ageing: A Policy Framework*. Available at www.who.int/ageing/publications/active/en/

15 Katz, S. (2000). Busy bodies: Activity, aging, and the management of everyday life. *Journal of Aging Studies, 14*(2), 135-152.

16 Canadian Council on Social Development (2005). "A concept paper on issues concerning seniors with disabilities and Comments on indicators proposed by ODI for Advancing Inclusion 2005". Unpublished. This analysis is based on a PALS question asking respondents to indicate when their condition began. Its accuracy may be limited by accurate recall of a date that may be far in the past.

17 Campbell, M. (1993). *Aging with a Disability: A Life course perspective*. Available at http://codi.buffalo.edu/graph_based/.aging/.conf/.life

18 Kailes, J., Isaacson, K. (1998). *Aging with Disability.* Available at www.jik.com/awdrtcawd.html

19 Janicki M., Dalton, A., Henderson, C., Davidson, P. (1999). "Mortality and morbidity among older adults with intellectual disability: health services considerations". *Disability and Rehabilitation*. May-June;21(5-6):284-94..

20 The Federal government recently sponsored a public opinion research study that discusses Canadian attitudes towards disabilities. Environics Research Group (2004) *Canadian Attitudes Toward Disability.* Available at: www.sdc.gc.ca/asp/gateway.asp?hr=en/hip/odi/documents/attitudesPoll/index.shtml&hs=pyp

21 Fry, P. S. (2000). "Whose quality of life is it anyway? Why not ask seniors to tell us about it?" *International Journal of Aging and Human Development, 50*(4), 361-383.

22 National Advisory Council on Aging www.naca-ccnta.ca/

23 Health Canada (1998). *National Framework on Aging.* Available at www.hc-sc.gc.ca/seniors-aines/nfa-cnv/index_e.htm

24 Tate, R., Lah, L. and Cuddy, E. (2003). "Definition of successful aging by elderly Canadian men: the Manitoba Follow-up Study." *The Gerontologist*, Vol. 43, No. 5.

25 Public Health Agency of Canada (2003). *A Guide for the Development of a Comprehensive System of Support to Promote Active Aging.* Available at www.phac-aspc.gc.ca/seniors-aines/pubs/paho/paho_toc_e.htm

26 Metcalfe, M. (2005). *Anecdotes on Aging: Real life perspectives*. Ottawa: Author.

27 Task Force on Active Living and Dignity for Seniors (Ianno Task Force) (2004). *Creating a National Seniors Agenda: Report of the Prime Minister's Task Force on Active Living and Dignity for Seniors.* Available at www.tonyianno.parl.gc.ca/documents/seniors_e_final.pdf

28 Public Health Agency of Canada (2003). *A Guide for the Development of a Comprehensive System of Support to Promote Active Aging*. Ottawa: Public Works and Government Services. Available at www.hc-sc.gc.ca/seniors-aines/index_pages/publications_e.htm

29 Fredrick, J. and Fast, J. (1998). Living Longer Living Better. *Days of our lives: time use and transitions over the life course.* Ottawa: Statistics Canada, Cat. No. 89-584 –MIE (6).

30 The National Survey of Giving, Volunteering and Participating was conducted by Statistics Canada in 2000 as part of the Voluntary Sector Initiative. Following consultation with voluntary sector organizations and others, a modified survey will be conducted every three years beginning in 2004. For more information visit www.givingandvolunteering.ca/reports.asp#2000.

31 Metcalfe, M. (2005). *Anecdotes on Aging: Real life perspectives*. Ottawa: Author.

32 Lowe, G. (2001). *Job Quality: The Key to Attracting, Developing and Retaining Workers of All Ages*, Presentation to IPMA-Canada National Training Conference, Fredericton, NB. Available at www.cprn.com/en/doc.cfm?doc=202.

33 Fast, J. E. & Frederick, J. (2004). The transition to retirement: when every day is Saturday. *Days of our lives: time use and transitions over the life course.* Statistics Canada, Catalogue No. 89-584-MIE (5).

34 Custom tabulation of the Survey of Labour and Income Dynamics by Statistics Canada.

35 Statistics Canada advises that due to small sample size, this figure should be used with caution.

36 Laville, A., et al., (1998). Elderly Workers. *Encyclopaedia of Occupational Health and Safety 4th Edition*, International Labour Office. Cited by the Canadian Centre for Occupational Health and Safety, 2002.

37 Ringaert, L. (2005). *Disability and Aging: Canadian Centre on Disability Studies Concept Aging*. Winnipeg: Canadian Centre on Disability Studies.

38 Public Health Agency of Canada (2005). *The Safe Living Guide: A guide to home safety for seniors*, Ottawa: Public Works and Government Services. Available at www.phac-aspc.gc.ca/seniors-aines/pubs/safelive/index.htm

39 Social Development Canada (2004) *Advancing the Inclusion of Persons with Disabilities: Government of Canada Report* 2004. Ottawa: Public Works and Government Services Canada. Available at www.sdc.gc.ca/asp/gateway/.asp?hr=en/hip/odi/documents/advancingInclusion04/index.shtml&hs=pyp

40 Canadian Council on Social Development (2003). Persons with Disabilities and Medication Use, *Disability Information Sheet* No. 11. Ottawa: Author. Available at www.ccsd.ca/drip/research/dis11/dis11.pdf

41 Statistics Canada (2002). *Participation and Activity Limitation Survey* (PALS) 2001. Ottawa: Statistics Canada. Available at www.statcan.ca/english/freepub/89-577-XIE/index.htm.

42 Health Canada (2000). *Canadians' Access to Insurance for Prescription Medicines.* Study conducted by Fraser Group and Tristat Resources. Available at www.hc-sc.gc.ca/hcs-sss/alt_formats/hpb-dgps/pdf/pubs/2000-htf-fass-acces-med/2000-htf-fass-acces-med_e.pdf

43 Cranswick, K. (2003): *General Social Survey 2002, Cycle 16, caring for an aging population*. Ottawa: Statistics Canada. Cat. No. 89-582-XWE.

44 Fast, J., Eales, J. & Keating, N. (2001). *Economic impact of health, income security and labour policies on informal caregivers of frail seniors.* Ottawa: Status of Women Canada. Available at www.hecol.ualberta.ca/rapp/documents/swc.pdf.

45 It is important to emphasize that many people with disabilities may also be contributors to the economy and/or care and support providers.

46 Numbers based on a projection of the growth in the total number of Canadian with disabilities between 2001 and 2026 using a method that applies the PALS 2001 disability rates to a series of general population projections provided by Statistics Canada for 2000 through 2026. See Appendix C for further details.

47 Statistics Canada (2002). General Social Survey. Op Cit.

48 National Advisory Council on Aging. (2004). *Seniors on the margins*: *Aging with a developmental disability* Ottawa: Public Works and Government Services. Available at: www.naca-ccnta.ca/margins/disability/pdf/margins-disability_e.pdf.

49 Canada Mortgage and Housing Corporation (1998). *Planning Housing and Support Services for Seniors*, Ottawa: Author.

50 Metcalfe, M. (2005). *Anecdotes on Aging: Real life perspectives*. Ottawa: Author.

51 Chapman, S. A. (2005 In Review). A 'materialist' lens on aging well: Special things in later life. *Journal of Aging Studies*.

52 Please consult Chapter 2 for more information on data from the Statistics Canada Residential Care Facilities Survey.

53 A full description of the Abbeyfield Parkdale house can be found at www.cmhc-schl.gc.ca/en/imquaf/afho/afadv/cohode/shfa/case2.cfm#full

54 Additional information is available at www.tc.gc.ca/pol/en/transed2007/message_TC_e.asp.

55 Policy Research Group (2004). *Mobility Challenges of an Aging Population: Impact for Accessible Transportation*, *Policy Research Group.* Ottawa: Transport Canada.

56 Auger, J. A. & Tedford-Litle, D. (2002). *From the inside looking out: Competing ideas about growing old*. Halifax: Fernwood Publishing.

57 Participation and Activity Limitation Survey 2001. The question related to the use of the Internet and a computer in the past 12 months.

58 World Health Organization (2002). *Active Ageing: A policy framework*. Available at: www.who.int/ageing/publications/active/en/index.html

59 People living with one of the following conditions : chronic bronchitis, emphysema, chronic fatigue syndrome, learning disorders, anxiety disorders, mood disorders, thyroid problems, glaucoma, cataract, intestinal disorders such as Crohn's or colitis, urinary incontinence, stroke, stomach or intestine ulcers, cancer, heart disease, epilepsy, diabetes, migraines, hypertension, back problems, arthritis or rheumatism, fibromyalgia, asthma, allergies other than food allergies, and food allergies.

60 Social Development Canada (2004). Advancing the Inclusion of Persons with Disabilities: A Government of Canada Report 2004. Ottawa: Public Works and Government Services Canada. Available at www.sdc.gc.ca/asp/gateway/.asp?hr=en/hip/odi/documents/advancingInclusion04/index.shtml&hs=pyp

61 The HUI is based on the Comprehensive Health Status Measurement System developed at McMaster University's Centre for Health Economics and Policy Analysis.

62 The index varies from –0.360 to 1.0. The higher it is, the better the health status. An index of 0.8 to 1.0 indicates very good to excellent health status, while an index of less than 0.8 indicates moderate to severe functional health problems. Many elements measured by the HUI3 are also indicators of deficiency and activity limitations, and are similar to the characteristics used to describe the types of disabilities cited in PALS.

63 Statistics Canada (2004). *Canadian Community Health Survey 2003 (Cycle 2.1).* Ottawa: Author. Cat No. 82M0013XCB

64 Chapman, S. A. (2005 In Review). "A 'materialist' lens on aging well: Special things in later life". *Journal of Aging Studies*.

65 For more on mental health promotion, visit the website of the Mental Health Unit of the Public Health Agency of Canada at *www.phac-aspc.gc.ca/mh-sm/mentalhealth/mhp/faq.html*

66 Analysis by the Office for Disability Issues of CCHS data, Cycle 2.1 (2003)

67 *Advancing the Inclusion of Persons with Disabilities: Government of Canada Report* 2004. Op Cit.

68 National Clearinghouse on Family Violence (1999). "*Abuse and Neglect of Older Adults: A Discussion Paper.* Ottawa: Public Health Agency of Canada. Available at: www.phac-aspc.gc.ca/ncfv-cnivf/familyviolence/html/agediscussion_e.html

69 Public Health Agency of Canada (2005). Report on Seniors' Falls in Canada. Ottawa: Public Works and Government Services. Available at: www.phac-aspc.gc.ca/seniors-aines/pubs/seniors_falls/index.htm

70 Canadian Institute for Health Information (2005). *2004 Report: Major Injury in Canada*. Ottawa: National Trauma Registry, page 14. Available at: http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=AR_26_E&cw_topic=26.

71 Canada Mortgage and Housing Corporation (2004). *About Your House: Preventing Falls on Stairs,* CMHC, 2004. Available at www.cmhc-schl.gc.ca/en/burema/gesein/abhose/abhose_079.cfm.

72 Kontos, P. C. (1998). Resisting institutionalization: constructing old age and negotiating home. *Journal of Aging Studies, 12*(2), 167-184

73 World Health Organization (2002). Active Aging: A Policy Framework. Available at www.who.int/ageing/publications/active/en/

74 Auger, J. A. and Tedford-Litle, D. (2002). *From the inside looking out: Competing ideas about growing old*. Halifax: Fernwood Publishing

75 It is probably equally true that seniors who do not feel well may not exercise. Further analysis is required to determine the extent to which health problems and levels of exercise affect one another within the population of seniors with disabilities.

76 Launois R. and Reboul-Marty J. (1995). "La qualité de vie: approche psychométrique et approche utilité-préférence" [Quality of life: the psychometric approach and the utility/preference approach], *Cardioscopies*, Vol. 34, pp. 673-678.

77 The SF-36 was elaborated by John E. Ware Jr., at the Institute for the Improvement of Medical Care and Health, New England Medical Center Hospitals. The questions of the SF-36 are based on the 245 original questions of the Medical Outcomes Study. Source of this description: Canadian Community Health Survey (CCHS) Cycle 2.1 (2003). Public use microdata file (PUMF). Specifications of derived and grouped variables. Statistics Canada, January 2005

78 Centre for the Study of Living Standards (2001) "The Financial Circumstances of Elderly Canadians and the Implications for the Design of Canada's Retirement Income System." In *The State of Economics in Canada: Festschrift in Honour of David Slater,* Patrick Grady and Andrew Sharpe (Ed.). Ottawa: Author.(eds), (Montreal and Kingston: Centre for the Study of Living Standards and Queen's University), 2001.

79 This chapter on income is largely based on data from the Survey of Labour and Income Dynamics (SLID). Statistics Canada has revised its previously published low-income figures to reflect population changes in the 2001 Census and other factors. As a result, estimates of low-income rates are substantially higher among working-age people with disabilities than previously reported. However, the impact of the revised rates among people with disabilities is entirely with those aged 16-64 where rates increased an average of 3.9 percentage points in each of the years 1999-2002. In contrast, the low-income rates for seniors with disabilities did not increase on average over this period. A smaller increase of 1.9% was observed among working age people without disabilities while seniors without disabilities had no increase on average across the years 1999-2002.

80 This report uses the after-tax measure in recognition of the important role played by the tax system for people with disabilities.

81 Statistics Canada (2003). *2001 Census: Analysis series, Aboriginal peoples in Canada: A demographic profile.* Ottawa: Author

82 Ibid.

83 Ibid.

84 Ibid.

85 Ibid.

86 Health Council of Canada (2005). *Health Care Renewal in Canada: Accelerating Change.* Toronto: Author. Available at http://hcc-ccs.com/report/Annual_Report/Accelerating_Change_HCC_2005.pdf

87 If comparing these rates to those published from the Participation and Activity Limitation Survey, readers will note that the Census rates are higher. The difference in rates is due to the two-stage sampling approach employed by PALS as well as by its more detailed disability screening questions. It is not possible to precisely state the Aboriginal disability rates that would be obtained using a PALS approach, but it seems highly likely

that a similar reduction would occur. A more detailed discussion of the PALS methodology and its effect on disability rates is available on the Statistics Canada website: www.statcan.ca/cgi-bin/imdb/p2SV.pl?Function=getSurvey&SDDS=3251&lang=en&db=IMDB&dbg=f&adm=8&dis=2 A more general discussion of the effects of survey methodologies on disability rates is found in Annex 3 of the technical report of *Advancing the Inclusion of Persons with Disabilities* (2001) available at www.sdc.gc.ca/en/hip/odi/documents/advancingInclusion/chap1.shtml

88 First Nations Information Governance Committee. Assembly of First Nations (2005). *Disabilities and Chronic Conditions Among First Nations Adults. First Nations Regional Longitudinal Health Survey 2002/03: Results for Adults, Youth and Children Living in First Nations Communities*. Ottawa: First Nations Centre, National Aboriginal Health Organizations.

89 Kinnon, D. (2004). *Advancing the Inclusion of First Nations, Inuit and Métis Persons with Disabilities: A Discussion Paper,* Ottawa: National Aboriginal Health Organization (for Social Development Canada).

90 Indian Affairs and Northern Development (1998). *Gathering Strength: Canada's Aboriginal Action Plan.* Ottawa: Public Works and Government Services Canada. Available at www.ainc-inac.gc.ca/gs/index_e.html

91 This profile of need is based on APS questions asking about additional features including modifications to doors or hallways, ramps, modifications to the bathroom, modifications to the kitchen, alerting devices and other special features.

92 First Nations Information Governance Committee. Assembly of First Nations. (2005). Op.cit.

93 *Background Paper for the Development of an Aboriginal Diabetes Strategy: Report of the Working Group*. (Draft, June 17, 1998). With permission of the Health Programs Analysis Division, First Nations and Inuit Health Programs, Medical Services Branch, Health Canada.

94 Statistics Canada. "Aboriginal Peoples Survey: Well-being of the non-reserve Aboriginal Population". (*The Daily*, Sept. 24, 2003). Ottawa: Author. Available at www.statcan.ca/Daily/English/030924/d030924b.htm

95 Demas, D. (1998). *One Voice: The Perspective of Aboriginal People with Disabilities.* Ottawa: Aboriginal Reference Group on Disability Issues.

96 Kinnon (2004). Op.cit.

97 Reading J. (1999). "An Examination of Residential Schools and Elder Health." Pp 27-54 in *First Nations and Inuit Regional Health Survey*. Ottawa: First Nations and Inuit Regional Health Survey Steering Committee.

98 First Nations Information Governance Committee. Assembly of First Nations (2005). Op.cit

99 Federal, Provincial and Territorial Advisory Committee on Population Health (1999). *Towards a Healthy Future: Second Report on the Health of Canadians and Strategies for Population Health: Investing in the Health of Canadians*. Ottawa: Public Works and Government Services. Available at www.phac-aspc.gc.ca/ph-sp/phdd/report/toward/report.html

100 Québec shares the concerns raised in the *In Unison* report. However, the Government of Québec did not take part in the development of this document because it wishes to assume control over programs for persons with disabilities for Québec. Consequently, any references in this document to joint federal/provincial/territorial positions do not include Québec.

101 Technical Advisory Committee (2004). *Disability Tax Fairness: Report of the Technical Advisory Committee on Tax Measures for Persons with Disabilities*. Available at www.disabilitytax.ca/text/committees_report-e.html#

102 The Report and the Government's response are available at: www.parl.gc.ca/committee/CommitteePublication.aspx?COM=8982&Lang=1&SourceId=121676

103 The Senate committee issued three interim reports in November 2004. These interim reports are available at www.parl.gc.ca/38/1/parlbus/commbus/senate/com-e/soci-e/rep-e/repintnov04-e.htm The full report will be released in December 2005.

104 Environics Research Group (2004). *Canadian Attitudes Towards Disability Issues.* Available at www.sdc.gc.ca/asp/gateway.asp?hr=en/hip/odi/documents/attitudesPoll/index.shtml&hs=pyp

105 While the Québec government subscribes to the general principles of the Labour Market Agreements for Persons with Disabilities (LMAPD, it did not participate in its elaboration. However, it does contribute by sharing information and best practices. The Québec government intends to continue treating this question with the federal government in a bilateral way. All references to joint positions of the federal, provincial and territorial governments in the LMAPD do not include the Quebec government. The Northwest Territories, Nunavut and the Yukon have confirmed their support for the principles and direction of the LMAPD. They will continue to provide labour market programs for persons with disabilities and will participate in the LMAPD in the future if outstanding fiscal issues are resolved.)

106 Statistics Canada (2005) *Population Projections for Canada, Provinces and Territories 2000-2026.,* (Catalogue 91-520-XIB). Ottawa: Statistics Canada.

107 Wolfson, M and Rowe, F. (2005). *Disability and Informal Support: Prospects for Canada*. Statistics Canada (unpublished). Carrière, Y., Légaré, J. and Keefe, J. (2004). *Projecting the Availability of Informal Support and its Impact on Chronic Home Care Services*. (funded by Health Canada).

108 Canada Mortgage and Housing Corporation (1998). *Evaluation of Housing Initiatives under the National Strategy for the Integration of Persons with Disabilities*. Ottawa: Author.

109 CMHC, R.A. Malatest & Associates, Auguste Solutions and Associates. (2003). *Residential Rehabilitation Assistance Program Evaluation.* Available at: http://dsp-psd.communication.gc.ca/Collection/NH15-421-2003E.pdf

110 Transport Canada (2003). *Straight Ahead—A Vision for Transportation in Canada.* Available at www.tc.gc.ca/aboutus/straightahead/menu.htm

111 Additional information is available at www.vac-acc.gc.ca/providers/sub.cfm?source=pro_research/currentprojects.

112 The Falls Prevention Initiative created a number of tools and resources that are available at www.phac-aspc.gc.ca/seniors-aines/index_pages/publications_e.htm#injury

113 In 2004, monthly CPPD benefits were paid to an average of 291,348 individuals and 89,267 dependent children. As of June 2005, the average monthly CPP disability benefit was $760 and the largest proportion of clients were between 60 and 64 years of age.

114 See First Nations Information Governance Committee. Assembly of First Nations. (2005). Op. cit. for a discussion of the issues arising in comparing disability rates from the RHS to those found in Statistics Canada surveys.

GIVE US YOUR FEEDBACK

The Government of Canada is committed to continually improving its reporting of disability issues to Canadians. We want to know what you think of this report, what you like best, and what you think needs to be changed or improved so that we can make the necessary adjustments.

We welcome your comments by mail, telephone, facsimile or e-mail.

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