Interim Report Card

Seniors in Canada 2003

by the National Advisory Council on Aging

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National Advisory Council on Aging | Conseil consultatif national sur le troisième âge
Canada

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What is the National Advisory Council on Aging?

The National Advisory Council on Aging (NACA) was created by Order-in-Council on May 1, 1980 to assist and advise the Minister of Health on issues related to the aging of the Canadian population and the quality of life of seniors. NACA reviews the needs and problems of seniors and recommends remedial action, liaises with other groups interested in aging, encourages public discussion and publishes and disseminates information on aging.

The Council has a maximum of 18 members from all parts of Canada. Members are appointed by Order-in-Council for two- or three-year terms and are selected for their expertise and interest in aging. They bring to Council a diversity of experience, concerns and aptitudes.

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Foreword

How well are Canadian seniors doing?

To answer this question, the National Advisory Council on Aging (NACA) examined certain aspects of the situation of Canadian seniors and published, in 2001, its first *Report Card: Seniors in Canada*. The 2001 *Report Card* rated seniors' well-being as reflected in measures of their **health status, access to quality health care**, **financial situation**, **living conditions** and **participation in society**. A grade was attributed and priorities for action were identified in each of these areas. The next Report Card, to appear in 2006, will assess general progress over five years.

In the interim, to ensure continued attention in the areas that the 2001 *Report Card* saw as requiring priority action, NACA is publishing this brief *Interim Report Card 2003.* Since this is a report on progress, no grades are given. Rather, information is updated and emerging trends or policy developments that hold promise – or raise red flags – for seniors are noted. Grading will continue in the next full Report Card.

Of the 30 million Canadians in 2001, 3.9 million were 65 and older. Seniors are the fastest-growing age group in the country: the increase in their numbers since the 1996 census (about 360,000) is enough to populate a mid-size Canadian city, such as London, Ontario, or Halifax, Nova Scotia. Issues that concern seniors should be high on every government's agenda.

The 2001 *Report Card*, this *Interim Report Card 2003* and those that will follow constitute NACA's "watching brief" on aging and seniors issues in Canada. Council invites governments at all levels, seniors' organizations, voluntary organizations and all groups concerned with seniors and with an aging society to use this tool in determining priorities for action and for advocacy.

Patricia Raymaker
Chairperson
National Advisory Council on Aging

NACA looks forward to readers' comments and suggestions concerning its Report Cards in the hope of developing an increasingly useful tool for bettering the lives of Canadian seniors.

1

How healthy are seniors?

How healthy are seniors?

Areas identified for action

With respect to health status, the 2001 *Report Card: Seniors in Canada* had identified three areas needing improvement: injury prevention, promotion of physical activity, and suicide prevention – especially for men.

New or updated information

- While the 65 and over population grew 3.7% between 1997 and 1999, hospital admissions showed seniors incurring slightly fewer unintentional injuries in 1999-2000 (73,113) than in 1997-98 (73,595), a decline of about 0.7%.[1] Similar trends are also seen for falls (see Chart 1).

- Seniors aged 65-74 showed an improvement in their physical activity levels, with 51.1% reporting being physically inactive in 2000-01, compared to 54.7% in 1998-99. Seniors 75 and older lagged in this area with 63.3% reporting being physically inactive in 2000-01, a little worse than the 62.5% in 1998-99.[2]

- Suicide among senior men 85 and older decreased slightly between 1997 and 1998 from 34.3 to 31.0 for every 100,000 men.[3]

Observations

- There has been slight progress in all three areas: a decrease in unintentional injuries and in falls, continued reduction in reported physical inactivity among seniors aged 65-74 and a decline in suicide rates among men aged 85 and older.

- Council is however concerned about the persistently high rate of falls among older seniors.

- Physical inactivity remains stubbornly high among seniors 75 years and older, although even mild activity has proven physical and mental benefits for seniors at all ages. Changing from a sedentary, physically inactive lifestyle, to do mild to moderate physical activity regularly is an important step toward maintaining or improving health.

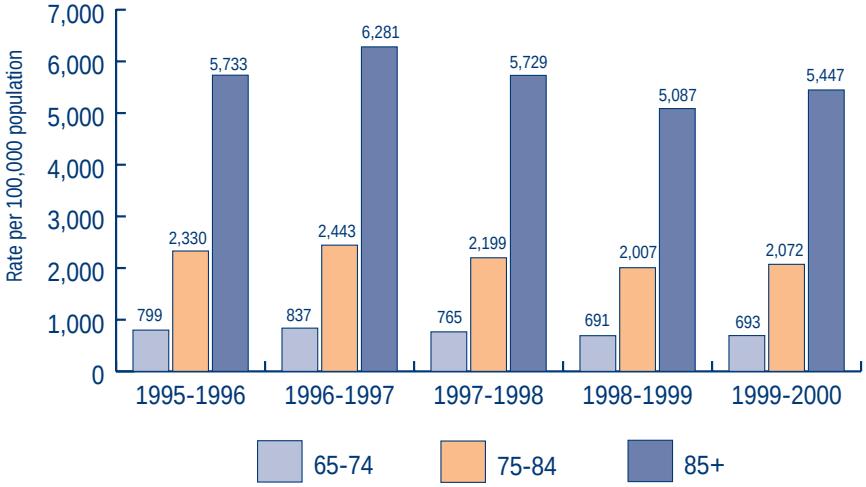
- The consistently higher suicide rates for men aged 85 and older compared to most other age groups is a longstanding problem that has not yet drawn the attention needed.

Emerging areas of promise and concern

- Seniors' life expectancy continues to increase and self-reported health,[4] as well as some aspects of mental health, are improving. Yet, at the same time, the percentage of seniors reporting major chronic diseases, including diabetes, high blood pressure and arthritis/rheumatism, has been rising. Also, more seniors than other age groups have become ill or have died as a result of new infectious diseases,

such as the West Nile virus and Severe Acute Respiratory Syndrome (SARS). NACA will expect Ministers of Health to pay particular attention to the needs of older Canadians in developing the Pan-Canadian Healthy Living Strategy and public health responses to emerging infectious diseases.

CHART 1. Falls requiring hospitalization have decreased for all seniors since 1995-1996, but remain very high for seniors over 85



Source: Canadian Institute for Health Information. "National Trauma Registry". Ottawa: 1998-2002 and Health Canada. "Canadian Injury Data: Mortality-1997 and Hospitalizations -1996-97". Ottawa: October 1999.

2

How well is the health care system serving seniors?

How well is the health care system serving seniors?

Areas identified for action

In terms of the health care system's accessibility, comprehensiveness, effectiveness, appropriateness and the degree of satisfaction of users, the 2001 *Report Card* had observed that there was not yet sufficient information to assess how well the health care system was serving seniors. This situation has been changing. Due to recent federal, provincial and territorial initiatives to improve the accountability of the health care system, new studies are shedding light on seniors' access to health care and their satisfaction with the care they receive. Evidence is available regarding the appropriateness of prescription drug use. Also reported is information concerning accessibility of geriatric specialist care, the cost of prescription drugs and the accessibility and comprehensiveness of home care.

New or updated information

- In 2001, a very high proportion of seniors (95.9%) reported having a regular family physician and their access to a physician exceeded the average for all Canadians (87.7%).[5]

- Fewer seniors than Canadians aged 15-64 complained about waiting too long for care in 2000-01 (see Chart 2).[6]

- A very high 90.2% of seniors rated the overall quality of the health care services they received during the previous 12 months as excellent or very good. This was the highest of all age groups, with Canadians aged 45-64 next highest at 87.2%.[7]

- In 2000, there were 144 geriatricians[8] in Canada, although an estimated 481 were needed. By 2006, the forecast is that there will be 198 geriatricians, but a need for 538.[9] Canada has 0.44 geriatricians per 100,000 population compared with 2.1 in Israel and 3.4 in the United States (the Royal College of Physicians of London, England, promotes a standard of about two per 100,000).[10]

- Seniors spend more for drugs than other age groups, despite coverage by drug benefit plans; for instance, Manitoba drug use data show that seniors in that province spent four times more per person for prescribed drugs in 1999-2000 than younger residents: $708 vs $177.[11]

- Although much of the higher drug costs of seniors results from having to take more medications, part of it also comes from higher drug prices: the retail prices of prescription drugs have risen every year since 1997.[12]

- Seniors relying on formal sources only for home care support received considerably fewer hours of assistance than those who relied on informal support or on a combination of formal and informal

support.[13] In 1996, seniors who relied exclusively on formal sources of support reported only 1.8 hours a week of assistance compared to 3.5 hours per week reported by those assisted by informal sources and 6.5 hours per week by seniors who received both formal and informal assistance (see Chart 3).[14] The more seniors relied on formal support, the greater their unmet needs for assistance with activities of daily living.[15]

- Withdrawal of housekeeping services from home care clients with low-level needs in British Columbia resulted in a decline in the health of these persons, as measured by increased hospitalization, admission to residential care and deaths.[16]

Observations

- The great majority of seniors consider the basic physician and hospital care they receive to be accessible and of good quality. But subjective ratings say nothing about the appropriateness of care, nor its effectiveness. These criteria can only be assessed by examining the care given in comparison to accepted standards of best practice and to the outcomes of treatment. By "best practice standard", many drugs are not being appropriately or effectively prescribed.

- Objective studies of home care confirm long-standing complaints from many recipients, providers and observers – access to home care services has been limited, with disturbing consequences for many seniors, and the services provided may not fully meet care needs.

- Many seniors are paying more than before for needed prescription drugs. Increases in out-of-pocket payments for medication can have negative health consequences for seniors with low and modest incomes.[17] Of particular concern is the growing cost burden of drugs for near-seniors, people 55-64, who have increasing health problems requiring medication but who are not covered by either public or private drug insurance plans.

- A worrisome trend is the shortage of physicians specialized in the care of seniors with complex health needs. This concern is shared by the Canadian Medical Association and Canadian Nurses Association who have expressed concern with the projected dearth of physicians and nurses in general to provide care to an aging population.

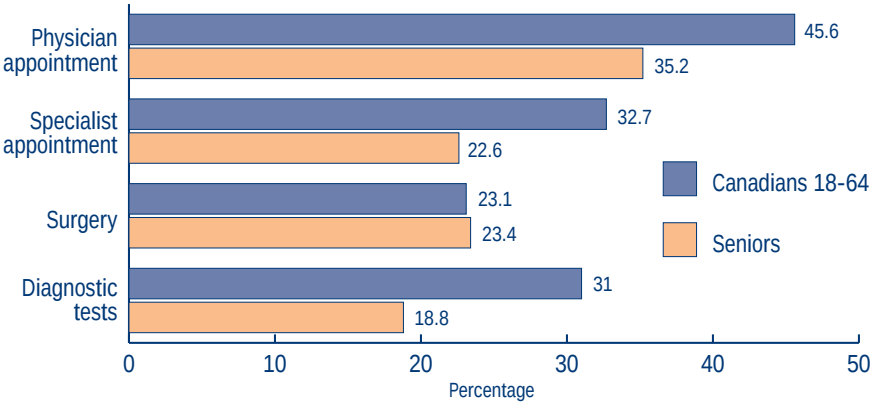
Emerging areas of promise and concern

- The 2003 First Ministers Accord on Health Care Renewal provides some much-needed direction and new investments in primary health care, catastrophic drug coverage, and core services for short-term acute home care, including mental health services and end-of-life care. The infusion of new funds should allow provinces and territories to devote more resources to long-term chronic home care, which serves predominantly seniors. Council will be watching for improvements in this sector of home care.

- Reports have been increasing about government underfunding and shoddy care in long-term care

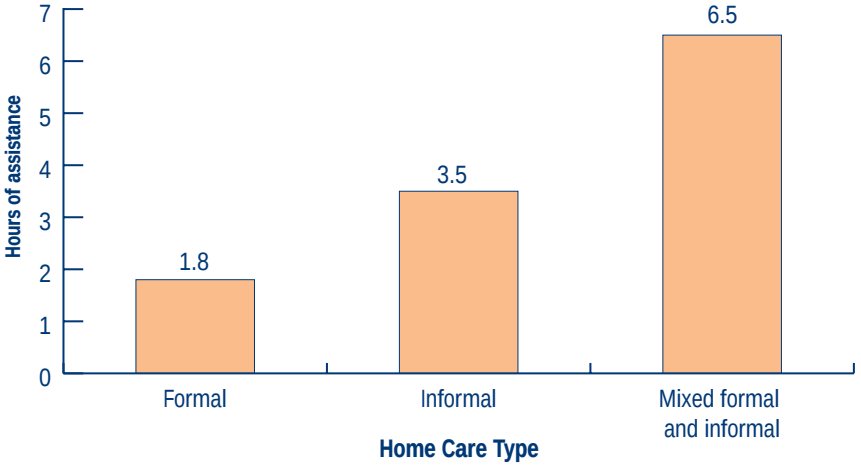
institutions, at the same time as the charges to residents for care have been rising in some jurisdictions. NACA will explore this issue further in the next Report Card.

CHART 2. Fewer seniors than younger Canadians said they waited too long for most health care services, 2001



Source: Health Analysis and Measurement Group. "Access to Health Care Services in Canada, 2001". Ottawa: Statistics Canada, 2002. Cat. No. 82-575-XIE.

CHART 3. Seniors who received only formal home care services in 1996 had the least hours of assistance



Source: Lafrenière, Sylvie, Carrière, Yves, Martel, Laurent and Bélanger, Alain. "Dependent seniors at home – formal and informal help". Health Reports. Vol, 14, No. 4. Statistics Canada: 2003.

3

How well are seniors faring economically?

How well are seniors faring economically?

Areas identified for action

The 2001 *Report Card*'s assessment of the economic status of Canadian seniors saw the situation of seniors living alone as requiring priority action, particularly that of senior women, who continue to have higher rates of low income than other seniors.

New or updated information

- The percentage of unattached senior women with low income (after-tax) declined from 22.0% in 1998 to 21.0% in 2000, while rates for unattached senior men remained stable at about 17.0%.[18]

- The average after-tax income of unattached senior women rose to $19,299 in 2000, from $18,960 in 1999 (see Chart 4).[19]

- At the same time unattached senior men were reporting an average after-tax income of $22,025 in 2000, down from $22,725 in 1999.[20]

Observations

- The increase in average after-tax income for unattached senior women is welcome news, but it illustrates how precariously close to poverty as defined by after-tax low-income cutoffs (LICOs) many of these women are.

- Although unattached senior men have substantially higher after-tax incomes than their female counterparts, their loss of net after-tax income warrants monitoring.

Emerging areas of promise and concern

- Senior families are falling behind economically. Between 1991 and 2000, the average after-tax income of senior families decreased by $553 (from $39,764 to $39,211) while the after-tax income of non-senior families increased by $6,585 (from $50,635 to $57,220).[21]

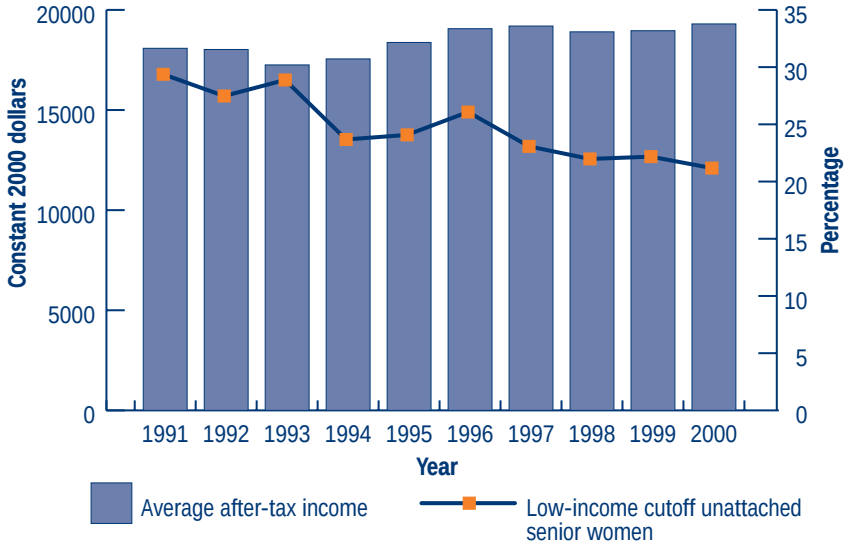
- Many seniors continue to have very modest means. While the percentage of seniors who have incomes low enough to be beneficiaries of the Guaranteed Income Supplement (GIS) has declined over the past decade, still 36% of seniors who get OAS also depend on the GIS. Huge variations exist in the percentage of seniors receiving the GIS, from 66% in Newfoundland and Labrador to 28% in Ontario. Women persistently constitute almost two out of every three GIS recipients. Moreover, as the over-65 population increases, the number of seniors who must rely on the supplement to make ends meet is

increasing: there were about 137,000 more GIS recipients in 2003 than in 1993.[22]

- These trends show that many seniors have little, if any, capacity to absorb higher living expenses. The cost of many essential products and services has increased, such as energy costs, property taxes, insurance rates, retail drug prices and the cost of drug benefit plans in some provinces. Moreover, since 2001, the downturns in financial markets have adversely affected many seniors' income from investments.

- The federal government is making a more vigorous effort to reach out to low-income seniors who are eligible for the GIS but who have not yet applied. NACA will report on trends in GIS uptake in Report Card 2006.

CHART 4. A small increase in the average after-tax income for unattached senior women lifts them above the low-income cutoff line



Source: Income Statistics Division. "Income in Canada, 2000". Ottawa: Statistics Canada, 2002. Cat. No. 75-202-XIE. 1992 LICO base

4

How supportive, enabling and safe are seniors' living conditions?

How supportive, enabling and safe are seniors' living conditions?

Areas identified for action

The 2001 *Report Card* indicated that priority action should be taken on two fronts: increasing the stock of affordable rental housing to alleviate core housing needs, and reducing the rate of economic crime victimization.

New or updated information

- PhoneBusters statistics on telemarketing fraud show that Canadians over age 60 accounted for almost 90% of those who reported being defrauded in 2001 compared with about 77% in 1999.[23]

Observations

- PhoneBusters data represent only the number of calls reporting phone fraud to this organization, and probably underestimates the actual prevalence of telemarketing fraud. The higher rates among older

Canadians may indicate either that seniors are the prime targets for this crime, or that they are more aware of PhoneBusters and willing to report having been the targets of fraud artists.

- Information on core housing needs derived from the 2001 Census is not yet available.[24]

Emerging areas of promise and concern

- Since 2001, the federal government has committed about $1 billion to help stimulate the creation of more affordable housing and has signed agreements with all provinces and territories to implement the first phase ($680 million) of the program. Besides increasing affordable housing for low-income Canadians generally, this initiative has also led to senior-specific housing in some jurisdictions. NACA will be monitoring effects of this program on the proportion of seniors in a situation of core housing need.

- More seniors, especially older seniors, are living alone. While many seniors prefer this independence, living alone can be associated with more loneliness, unmet daily needs and increased personal safety risks. For seniors experiencing considerable difficulty managing alone as they become frail or disabled, there is a growing need for high quality alternative supportive housing options. Selection of a retirement home can be chancy as a lack of a consistent process to ensure quality standards in services – either through regulation or accreditation – means there are some great homes and some awful ones.

- In partnership with other stakeholders, Canada Mortgage and Housing Corporation plays a significant role in identifying, promoting and facilitating a greater range of housing choices for seniors. Yet, NACA concluded in the 2002 *Position Paper on Supportive Housing* that more federal funding is necessary to stimulate new developments to meet rising needs.

5

How fully are seniors participating in society?

How fully are seniors participating in society?

Areas identified for action

For this aspect of seniors' situation, the 2001 *Report Card* focused on the need to abolish mandatory retirement at age 65 in provinces where it still existed.

New or updated information

- Ontario has announced it will make mandatory retirement illegal, except where negotiated, by amending the definition of "age" in the *Human Rights Code* and in other legislation.

Observations

- Age discrimination remains a societal norm of exclusion for seniors in those provinces where mandatory retirement policies based on age continue to be legally permitted. These are: British Columbia, New Brunswick, Nova Scotia, Saskatchewan, and Newfoundland and Labrador.[25]

Emerging areas of promise and concern

- Seniors are rapidly catching up to younger Canadians in using the Internet to communicate and to obtain information and their enrolment in formal educational activities has been increasing. As our society becomes more complex and more reliant on easy and rapid access to information, it is vital that seniors have opportunities to update their knowledge and skills to participate fully.

- Proportionately fewer seniors are volunteering than a few years ago, but those who do volunteer are putting in more hours. Trends in seniors' volunteer participation warrant monitoring because their continued engagement contributes to the social good as well as to their personal well-being.

- Seniors' labour force participation rate has been declining in recent years; at the same time, the proportion of seniors actively looking for paid work has increased slightly. As seniors become ever rarer in the workplace, the exclusion of those who want – or need – paid employment may become more firmly entrenched in practice, if not in policy. To facilitate seniors' continued participation in the labour force, explicit initiatives to stimulate lifelong learning, to develop skills and to accommodate a work/life balance are needed.

The last word

The last word

A few positive changes have occurred since *Report Card: Seniors in Canada 2001*. One more province will soon prohibit mandatory retirement at age 65. Some aspects of seniors' health and safety have improved slightly too. There is now much more information about the perceived performance of the publicly-insured health care system, but it should be interpreted cautiously. When people rate their satisfaction with respect to care, they do so without knowing whether the care they have received really meets objective standards of quality. Little, in fact, is known about the effectiveness of care in most areas, particularly for seniors, although the evidence regarding drug prescribing practices is disturbing. As well, there are significant gaps in knowledge regarding home care and long-term institutional care, which serve some of the most vulnerable and voiceless seniors in society.

Council repeats the recommendation it made in *Waiting for Romanow* (2002) that governments be audited by an independent third party on both the performance and the quality of health care. Better public accountability is urgently needed because without hard evidence, governments face no compelling political pressures to improve care.

There is enough hard evidence in some areas to justify action now:

In the area of health, targeted activities in health promotion and disease prevention are needed to control the rising rates of preventable chronic disease and to help seniors with chronic illness manage their conditions effectively. Action in health care for seniors includes improving access to, and adequacy of, home care and increasing the supply of health professionals to care for seniors.

Some issues need more exploration and closer monitoring to anticipate policy directions:

The precarious economic situation of unattached senior women has been a long-standing problem, yet now unattached senior men and senior families are appearing on the radar screen. The impact of rising costs for essential goods and services on economically vulnerable seniors should be assessed. Seniors living alone, or in retirement homes and long-term care institutions warrant more attention. Finally, seniors' rates of participation in paid work and in volunteer activities should be probed, particularly if they continue to drop.

In the past decade, there have been significant federal initiatives addressing seniors' well-being or the issues of an aging population: pension reform, health care renewal and the creation of the Canadian Institutes of Health Research – Institute of Aging. While these measures are undeniably positive, the federal government has **forgotten** its electoral commitment to

promote healthy aging, has cut back on its support for seniors' community programs and organizations, and has not shown leadership in implementing the United Nations' Madrid *International Plan of Action on Ageing*[26] here in Canada. New and emerging government initiatives in healthy living, health care, affordable housing and lifelong learning can lead to some future improvements in seniors' health and well-being, but there is a danger that seniors' specific needs will be overlooked in generic, "one-size-fits-all" programs.

The federal government seems to believe that it has solved the "demographic aging problem", but its actions to date are not sufficient. Without real federal leadership – especially in implementing the UN *Plan of Action on Ageing* at home – the needs of many seniors today will remain unmet and **Canada will be ill-prepared when the growth in the seniors' population accelerates eight years from now.**

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3 Lindsay, Colin. *A Portrait of Seniors in Canada*. Third Edition, Ottawa: Statistics Canada, 1999. Cat. No. 85-519 XPE, p. 61.

4 *Self-reported health means that seniors rate their own health status as being excellent, very good, good, fair or poor. Self-reported health is generally accepted as a good indicator of a person's health.*

5 Health Analysis and Measurement Group. *Access to Health Care Services in Canada, 2001*. Ottawa: Statistics Canada, 2002. Cat. No. 82-575-XIE, pp. 28-29. Analysis performed by Division of Aging and Seniors, Knowledge Development Unit.

6 *Ibid.*

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8 *A geriatrician is a specialist in geriatric medicine, i.e. that deals with the problems and diseases of old age*.

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13 *Informal help is performed by family, friends or neighbours; formal help is provided by paid employees of for-profit or not-for-profit organizations.*

14 Lafrenière, S., Carrière, Y., Martel, L., and Bélanger, A. "Dependent seniors at home – the balance of formal and informal help." *Health Reports*, Vol 14, No. 4. August, 2003. Statistics Canada. Cat. No. 82-003, p. 35.

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19 *Ibid,* p. 61.

20 *Ibid,* p. 61.

21 *Ibid,* p. 61.

22 *Statistical Bulletin Canada Pension Plan Old Age Security*. Human Resources Development Canada, January-May 2003. The 2003 data are based upon the five months January-May, 2003.

23 Phonebusters. *Statistics on Phone Fraud*. http://www.phonebusters.com/Eng/Statistics/canada_stats1_2002.html. Tables 2001, 2002.

24 *A household is said to be in core housing need if its housing falls below at least one of the adequacy, suitability or affordability standards and it would have to spend 30% or more of its income to pay the average rent of alternative local market housing that meets all three standards.*

25 Human Resources Development Canada, "Work-Life Balance in Canadian Workplaces," http://labour-travail.hrdc-drhc.gc.ca/worklife/aw-retirement-legislative-02-en.cfm

26 *The Plan was put in place in 2002 at the Second World Assembly on Ageing, in Madrid. http://www.un.org/esa/socdev/ageing/waa/index.htm*