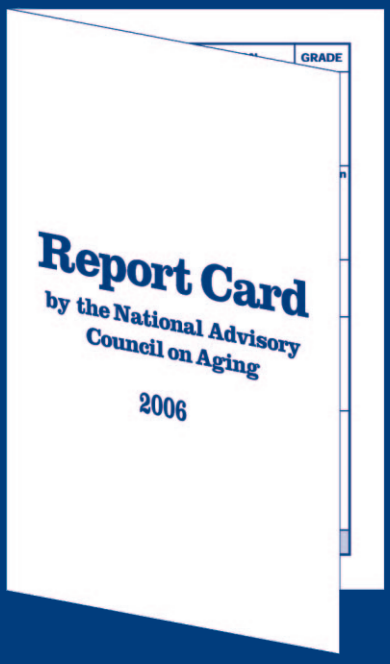
Seniors in Canada

2006 Report Card

National Advisory Council on Aging



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National Advisory Council on Aging

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Canada

Seniors in Canada

2006
Report Card

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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 variety of experiences, skills and aptitudes.

Council members (2006)

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Robert Dobie, Quebec

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Roberta Morgan, Yukon

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Mike Sommerville, Ontario

Dedication

The National Advisory Council on Aging dedicates this document to the memory of Betty Havens, who died on March 1, 2005. Betty Havens devoted her entire professional life to improving the lives of older adults. In 1971, she designed and conducted the Aging in Manitoba Longitudinal Study and served as its principal investigator from that time onward. That study is to this day the longest and most comprehensive study of aging in Canada. Betty received numerous awards and distinctions during the course of her life, the latest being the Order of Canada in 2005.

NACA wishes to express its deep appreciation for Betty's contribution to our knowledge on aging in Canada and for her valuable advice as a member of the Expert Advisory Committee that guided the creation and publication of NACA's first Report Card on seniors, in 2001.

Acknowledgements

The creation of this document has been a collective effort by many who share a commitment to seniors' well-being. The National Advisory Council on Aging wishes to thank all those who contributed their time and effort to the development, review and production of this document.

NACA gives special thanks to the Expert Advisory Committee members who helped select the indicators and the data sources, reviewed trends, provided valuable guidance on the attribution of grades and gave general feedback to the Council, throughout the project. The Expert Advisory Committee consisted of: Bubs Coleman, Robert Dobie, Janet Fast, Réjean Hébert, Gerald Hodge, Laurent Martel, Lynn McDonald, Louise Plouffe, Luis Rodriguez and Mohindar Singh. Their affiliations are presented on page 60.

Chapter authors were Ian Clark, Marie-Lynne Foucault and Barbara Sérandour, Division of Aging and Seniors, Public Health Agency of Canada.

Foreword

NACA's *2006 Report Card* follows up on an examination of the situation of seniors in Canada undertaken several years ago, that culminated with the publication of a first Report Card on seniors, in 2001. NACA's Report Cards rate seniors' well-being by measuring their health status; access to quality health care; financial situation; living conditions; and participation in Canadian society.

NACA's *2001 Report Card* sought to answer the question: "How well are Canadian seniors doing?" The Council hoped that its monitoring and assessment of the situation would "sustain the momentum for policy action to improve the health and well-being of seniors in Canada." In 2003, NACA published an Interim Report Card, focusing on the progress made – or not made – in the areas identified as *priorities for action* in the *2001 Report Card*.

The *2006 Report Card* continues to report on the situation of Canada's seniors – based on more recent data – and examines the trends, where possible, by comparing the current situation to the one that prevailed in 2001. NACA hopes that this analysis will sharpen the focus on priority areas for action and re-energize the will of those interested in improving the lives of seniors.

We look forward to readers' feedback on the *2006 Report Card* in the hope that this tool will become an increasingly useful one for improving the health and quality of life for seniors in Canada.

Robert Dobie
NACA Chairperson

Table of contents

Introduction

This report presents an analysis of national data on Canadian seniors (those aged 65 and older) related to health status, access to quality health care, financial situation, living conditions and participation in Canadian society.

As was the case in NACA's first Report Card in 2001, the 2006 edition was developed in consultation with gerontology experts, national seniors' organizations and federal government officials working in aging and seniors' policy. With the help of these experts, NACA identified the best measures – or indicators – to evaluate how well seniors are doing in key policy areas, and interpreted the "story" told by the evolution of these indicators over the last five years. This Report Card evaluates seniors' well-being by asking the same five questions as in 2001:

- How healthy are seniors?
- How is the health care system serving seniors?
- How well are seniors faring economically?
- What are seniors' living conditions?
- How are seniors participating in society?

How this report is organized

Each chapter of this report deals with one of the five questions. For each, the "**About the information**" section describes the data sources used and highlights the various changes since the 2001 Report. The "**Report**" section then summarizes the findings of the chapter.

The "**Summary table**" presents the indicators used, notes the reference period and depicts a trend, if one is evident. When interpretation of the information was possible, a grade was given for each indicator.

The "**Strengths**" and "**Weaknesses**" sections provide an analysis of the results. Many of the indicators are discussed in both sections, given that certain aspects of a particular indicator may represent a positive trend, while other aspects of the same indicator may represent a negative development for seniors. Finally, "**Priorities for action**" are highlighted, based on the challenges identified.

"**Data sources**" and "**References**" used to prepare this report are presented at the end of each chapter.

Grading

Attributing grades remains a subjective exercise and of course, not all readers will agree with NACA's evaluations. The Council feels that the grading exercise has been greatly improved by the use of a more transparent and objective approach based on the following four steps:

1. Establish the **trend direction** of each indicator (i.e., is the situation improving, worsening or stable?);
2. Evaluate the **current situation** of each indicator (i.e., is the situation intrinsically good, bad or undetermined?);
3. Translate these two dimensions (i.e., trend direction and current situation) into a grade for each indicator; and
4. Assign a grade for each question and an overall grade for the Report Card (see box "How were the questions graded?").

The grades evaluating the indicators are the following:
A – Very good;
B – Good, with improvements needed;
C – Satisfactory, with significant improvements needed; and
D – Unsatisfactory.

For each indicator, the **trend direction** was established using 95% confidence intervals[1] to compare the estimates available at the time of the *2001 Report Card* with the most recent estimates available, covering a five year period. The comparison focused primarily on the changes for all seniors (those aged 65 and over) but age and sex differences are noted when they are known and significant. When confidence intervals were not available (most of the indicators in questions 3, 4 and 5) but a trend was apparent, the Expert Advisory Committee helped determine the trend. Differences with respect to trends are mentioned in the report only if they are considered significant. Otherwise, the trend is considered to be "stable."

The evaluation of the **current situation** was based on comparisons with other age groups, with other countries from the Organisation for Economic Co-operation and Development (OECD), and on the opinions of experts in the field.

Where possible, shortcomings or limitations in the evaluation pertaining to an indicator are discussed – either in the beginning of each section or in the written text following. For example, as it was not possible to interpret certain data pertaining to "seniors living alone," a grade was not assigned. Also, because the grade for each indicator is based on both the trend direction *and* the current situation, it was possible for some indicators to show a trend that is "stable" yet still receive either a good or bad grade, depending on the evaluation of the *current* situation. In another case, a trend could be "unknown," yet still be graded.

[1] A statistical analysis to identify those dimensions in which there has likely been real change rather than a fluctuation in results caused by random occurrences.

How were the questions graded?

For each question, the grades assigned to the indicators were translated into a score (A=4, B=3, C=2 and D=1). Then, the scores were averaged and a grade was attributed based on the table below:

From	To	Grade
1	< 1.5	D
1.5	< 1.75	C-
1.75	< 2.25	C
2.25	< 2.5	C+
2.5	< 2.75	B-
2.75	< 3.25	B
3.25	< 3.5	B+
3.5	4	A

The **overall grade** is an average of the five questions.

This method assumes that each indicator has the same "weight" within its question, and that the grade assigned to each question contributed equally to the overall grade.

Comparability with the 2001 Report Card

There are significant improvements in the number and the quality of indicators used for the *2006 Report Card*, as well as in the grading method developed. The data obtained to measure the indicators are more substantial – allowing for a more in-depth analysis of datasets as opposed to relying on published data only. Another important improvement in this edition is the development of indicators and data that allow the Council to evaluate how well the health care system is serving seniors (question 2). In the 2001 edition, the available data were of insufficient quality to provide an answer to this question.

These improvements make it somewhat difficult to compare the grading of this edition to that of 2001. For example, in the 2001 edition, question 2 was not evaluated, grades were not given for indicators and overall grades were solely based on the trend direction. Also, since the 2001 version of the Report Card was the first edition, its reference periods were larger than this current edition, which focuses on the last five years. Notwithstanding these limitations, the Council does, at the end of this report, make an overall evaluation that compares the current situation to the one that existed in 2001.

Limitations

Although there are substantial improvements in the *2006 Report Card*, limitations remain. Most of the data presented are based on people *living in households*; this represents 93% of all seniors, but only 66% of those aged 85 and over.[2] The exclusion of institutionalized seniors in the vast majority of surveys limits the discussion on older seniors to a sub-population of seniors – those with better health and with specific characteristics. This limitation applies particularly to Question 1 (health status), but to the other questions as well. Some surveys also excluded people living in Yukon, Nunavut and the Northwest Territories. Also, most data are self-reported, allowing for possible bias (certain questions may elicit "socially acceptable" answers rather than an admission of reality). However, many researchers give primacy to someone's own evaluation of their situation over so-called "objective" measures.

This Report Card analyzes national data for Canadian seniors (those aged 65 and over). This category encompasses more than 4.2 million persons and represents a tremendous diversity of situations based on age, sex, life history, income, regional and cultural dimensions, etc. The discussion focuses primarily on the overall situation of seniors but often notes differences by age and sex. Differences pertaining to individual provinces or territories, to Aboriginal peoples, immigrant or marital status or income are not described systematically, but rather, only when they are relevant.

[2] In 2001, 23% of men and 35% of women aged 85 and over lived in long-term care institutions.

Question 1: How healthy are seniors?

Overview

The health status of seniors is obviously an important determinant of their well-being and life satisfaction. In this edition, NACA revisited most of the topics identified in the 2001 Report, including: life expectancy; self-assessment of health status; personal health practices; injuries; falls; mental health and suicide. New indicators helped refine the evaluation; they include: chronic diseases in greater detail, activity limitations, hip fractures, nutrition, weight and oral health.

About the information

- Much of this chapter is based on the Canadian Community Health Surveys (CCHS). The initial results of CCHS Cycle 3.1 – which cover the first six months of 2005 (January to June) – have been compared with those of CCHS Cycle 1.1 (2000-01). When 2005 data were not available for a specific indicator, comparisons were drawn between CCHS Cycle 2.1 (2003) and the National Population Health Survey (NPHS) of 1998-99.[3]
- Due to a lack of recent data, the "sense of coherence" indicator was replaced by self-assessment of mental health.
- New data on nutrition from CCHS 2.2 (2004) have been an important contribution to this chapter of the *2006 Report Card*.

Report

GRADE: B -

The health picture for seniors is one of contrasts. There are many positive aspects: life expectancy at age 65 has improved and progress has been made in terms of functional health. Seniors assess their own physical and mental health in largely positive terms. Further, rates of chronic pain and problems of being underweight are in decline. These improvements are less marked among women – particularly the most elderly.

Negative developments include increasing obesity among seniors and increasing rates of chronic diseases. Also, there have not been any satisfactory improvements in several areas such as physical inactivity, and injuries and falls (with the exception of hospitalizations for hip fracture). Further, suicide rates among senior men remain high.

[3] These surveys differ somewhat in terms of the proportion of interviews conducted by telephone and in person, which can affect certain answers.

Summary table – Question 1

Topic	Indicators	Reference period	Trend direction	Grade
Aggregate indicators	Life expectancy at age 65	1999 and 2003	Improving	A
	Dependence-free life expectancy at age 65	1996 and 2002	Men: Improving Women: Stable	B
	Self-assessment of health	2000-01and 2005	Improving	A
	Functional health	1998-99 and 2003	Improving	B
Chronic diseases	One or more chronic conditions	2000-01 and 2005	Worsening	C
	Arthritis or rheumatism		Worsening	C
	Diabetes		Worsening	C
	Hypertension		Unknown	—
	Heart disease		Improving	B
	Chronic pain or discomfort	1998-99 and 2003	Men: Improving Women: Stable	B
Activity limitations	Dependence in activities of daily living (ADL)	1998-99 to 2005	Stable	C
	Dependence in instrumental activities of daily living (IADL)	1998-99 to 2005	Men: Stable Women: Worsening	C
Personal health practices	Physical activity	2000-01 and 2005	Men: Worsening Women: Stable	C
	Smoking	2000-01 and 2005	Stable	B
	Nutrition	2004	Unknown	C

Summary table – Question 1 (cont.)

Topic	Indicators	Reference period	Trend direction	Grade
Injuries, including falls	Injuries	1998-99 and 2003	Stable	C
	Hospitalizations due to falls	1998-99 and 2002-03	Stable	B
	Hospitalizations for hip fracture	2000 and 2005	Improving	B
Physical health	Obesity	2000-01 and 2005	Worsening	C
	Underweight	2000-01 and 2005	Improving	B
	Oral health	2003	Unknown	—
Mental health	Self-assessment of mental health	2002 and 2005	Improving	A
	Suicide	1997-99 and 2001-03	Stable	B

Strengths

- **Life expectancy at age 65** has continued to increase over the past five years. On average, a 65-year-old man can expect to live an additional 17.4 years, and a 65-year-old woman, an additional 20.8 years. These figures place Canada among the OECD countries with the highest life expectancy at age 65. Between 1999 and 2003, life expectancy at age 65 increased by 1 year for men and 0.6 years for women.
- Trends with respect to **dependence-free life expectancy at age 65** diverged somewhat for men and women between 1996 and 2002. Men saw their dependence-free life expectancy increase by 0.5 years, reaching 13.2 years in 2002. Dependency-free life expectancy for women was also 13.2 years in 2002, which is almost unchanged from 1996.
- Seniors continue to **view their health in positive terms**, with an improvement noted in this area between 2000-01 and 2005. In 2005, 74% of seniors assessed their health as good, very good or excellent, compared to 70% five years earlier. The increase is somewhat greater among men than women, but can be observed among persons aged 65 to 74, as well as those aged 75 and older.

- There have been substantial improvements in the area of seniors' **functional health**, particularly among men. This indicator summarizes eight dimensions of functioning (sight, hearing, speech, mobility, dexterity, emotion, cognitive abilities and pain). In 2003, 74% of men reported being in very good or perfect functional health, compared to 66% in 1998-99. Among women the increase was only one percentage point, rising from 63% to 64%.
- Recent Statistics Canada research showed that the percentage of **seniors in good health** was approximately the same, whether they lived in urban or rural areas.[4]
- The proportion of senior men reporting moderate or severe **chronic pain** decreased from 22% to 18.5% between 1998-99 and 2003. The decline was non significant for women. Pain substantially increases the risk for activity limitations or dependency.
- There are positive developments regarding **hospitalizations for hip fractures**. Canadian Institute for Health Information (CIHI) data show a significantly reduced annual hospitalization rate for hip fracture between 2000 and 2005, dropping from 618 to 544 per 100,000 persons aged 65 and older during this period.
- The percentage of daily **smokers** declined over the past five years, from 10.4% to 9.3% (although the difference is not statistically significant). Seniors smoke less than other adult Canadians (approximately 20% of Canadians between the ages of 20 and 64 are daily smokers). More than one-third of seniors have never smoked (48% of women and 19% of men) and 13% of seniors indicated that they had stopped smoking over the past five years.

Oral health

CCHS 2.1 (2003) contained questions on oral health, a subject under-represented in earlier Canadian surveys. The results showed that 20% of seniors are unable to chew a raw apple or hard foods. Difficulty chewing increases with age and affects 31% of women aged 85 and over.

Such problems limit people's food choices, which can have an impact on nutrition and the evolution of many diseases. They also cause people to alter their social habits, most notably by isolating themselves at meal time.

Over the last several years, seniors' contact with a dental professional and insurance coverage for dental expenses increased (see Question 2).

- Being **underweight** remains a largely unrecognized problem, and is associated with malnutrition and frailty. Underweight seniors are at increased risk for falls and fractures, particularly hip fractures. The current definition of underweight is a body mass index (BMI) of less than 18.5.[5] Health Canada recognizes that this standard is less appropriate for persons aged 65 or more. Consequently, based on a number of epidemiological studies, the standard for the Report was set at 22.[6] When this innovative definition was applied, 17% of seniors were found to be underweight in 2005, a reduction of 3 percentage points compared to

[4] Four criteria were used to define good health: good functional health, independent in activity of healthy living (IADL), self-perceived mental health and self-perceived physicial health. Sheilds, M. and L. Martel. *Healthy living among seniors*.
[5] BMI is calculated by dividing a person's weight in kilograms by the square of their height in metres. Based on the usual standard, 2.5% of seniors would have been considered underweight in 2005.
[6] Standard was suggested by Dr. Hélène Payette, a specialist in seniors' nutrition and body weight.

2000-01 figures. This problem is more prevalent among senior women (21% are underweight, compared to 12% of senior men).

- Seniors view their **mental health** in very positive terms. In 2005, 95% of seniors considered their mental health to be good, very good or excellent, an increase of 1.5 percentage points over 2002.
- In May 2006, the Canadian Coalition for Seniors Mental Health published **best-practices national guidelines** on depression, delirium, suicide risk and prevention, and mental health issues in long-term care settings.

Weaknesses

- The positive trends reported at the national level with respect to **life expectancy, dependence-free life expectancy** and **perceived health status** actually mask significant discrepancies. For example, in Nunavut and the Northwest Territories, which have an important Aboriginal population, life expectancy at age 65 was almost four years lower than the national average in 2003.[7]
- Not surprisingly, the percentage of seniors reporting overall good health decreases with **income**. In 2003, 62% of seniors with the highest income level were in good health compared to only 41% of seniors with low or lower-middle income.[8]

Aboriginal peoples

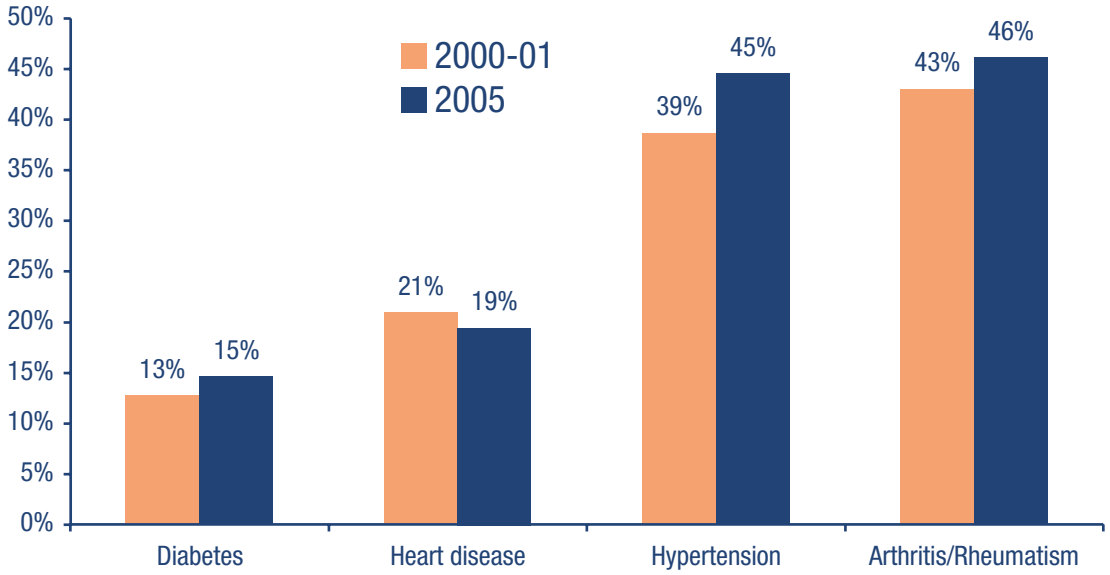
Aboriginal seniors living off-reserve are more likely to view their health status as fair or poor compared to Canadian seniors as a whole (44% vs. 30% in 2001), and to report chronic conditions such as diabetes, which affected close to 25% of senior women and 20% of senior men in 2001. According to Health Canada, there is strong evidence that the prevalence of diabetes is even higher among the Aboriginal population living on-reserve.

Source: Aboriginal Peoples Survey 2001.

- The prevalence of **chronic diseases** is increasing. In 2005, 91% of seniors reported one or more chronic health conditions as diagnosed by a health professional, compared to 87% in 2000-01.
- Some **chronic diseases** are more prevalent than they were five years ago, though **heart disease is an exception** (chart 1.1). It is important to note that the prevalence of **hypertension** has increased significantly during the past five years, rising from 39% to 45% between 2000-01 and 2005. While at first glance this appears to be a negative trend, the change may be explained – at least in part – by the adoption of new diagnostic criteria.

[7] However, life expectancy for these territories should be interpreted with caution due to small underlying counts.
[8] M. Sheilds and L. Martel, *op. cit.*

Chart 1.1 Percentage of seniors affected by selected chronic conditions, 2000-01 and 2005



Source: CANSIM and CCHS data analyzed by PHAC.

- Men and women are affected differently by chronic diseases (table 1.1).

Table 1.1 Prevalence of selected chronic diseases for seniors, by sex, 2005

	Men	Women
Diabetes	17%	13%
Heart disease	23%	17%
Hypertension	41%	48%
Arthritis and rheumatism	37%	54%
Chronic pain*	13%	23%
At least one chronic condition	89%	93%

* 2003 data

Source: CANSIM data and CCHS data analyzed by PHAC.

- Due to increasing health problems as they age, seniors are more limited in their activities than younger Canadians. Still, the vast majority of seniors who reside at home are independent. In 2005, only 7% of seniors reported needing help with **activities of daily living** (ADL) such as bathing, dressing, eating, taking medications, or moving from room to room. This level of dependency remains almost unchanged compared to those of 2000-01 and 2003.
- **Instrumental activities of daily living** (IADL) include activities such as meal preparation, errands, appointments and housework. In 2005, 22.4% of seniors living at home needed help with one or more of these activities, an increase over the rate of 19.5% observed in 1998-99. This change is explained by the increased IADL dependency for senior women (from 23% to 28%), while this dependency remained around 15.5% for men.

- A complete analysis of activity limitations requires consideration of people living in **long-term care institutions.** In 2001, 7.4% of seniors – and 32% of those aged 85 and over – were living in health care institutions (see Question 2).

Seniors with disabilities

Disability rates increase with age, rising from 31% in those aged 65-74, to 53% in the 75+ age group (2001). The overall disability rate for persons aged 65 and over is 40.5%. Disabilities most commonly affect seniors in the following areas:

- mobility (32% of seniors)
- agility (29%)
- pain (25%)
- hearing (16%)

Source: A Profile of Disability in Canada, 2001 – Tables.

- Despite the important role played by **physical activity** in preventing chronic disease and dependence and enhancing mental health, most seniors are still physically inactive.[9] In fact, this situation has not changed since the *2001 Report Card*. In 2005, the rate of inactivity among seniors was 62%. Among men, the rate of inactivity actually increased from 53% to 55% between 2000-01 and 2005. Women's rate of inactivity was even higher (67% in 2005).
- This sedentary trend is not unique to seniors: up to age 74, the rate of inactivity among seniors is equal to that of other adult Canadians (between 56% and 58% in the 35-64 age range versus 56% for those aged 65-74). Still, low activity levels that persist as one ages are a source of concern since research evidence demonstrates it is never too late to reap the health benefits of increased physical activity.
- Three quarters of women aged 75 and older were inactive in 2005. It should be noted that health problems are not the only reason for explaining physical inactivity among seniors. In many cases, physical activity is simply not incorporated into day-to-day living due to a lack of awareness of its importance in later life, or due to ageist attitudes that still negate its relevance.
- In 2005, **seniors who smoked daily** were smoking an average of 15 cigarettes a day. Half of these daily smokers had been smoking for 52 years.
- Improved eating habits help reduce chronic disease, dependence on drugs and the use of health care services. Yet, as was the case for younger Canadians, many seniors did not eat a balanced **diet** in 2004 (table 1.2).

[9] This indicator is based on responses to questions about the frequency, duration and intensity of participation in leisure-time physical activity.

Table 1.2 Seniors' eating habits (71 and older), by sex, 2004

	Men	Women
Not enough fruits and vegetables*	52%	60%
Not enough milk products*	79%	84%
Not enough grain products*	43%	66%
Too much fat**	21%	17%

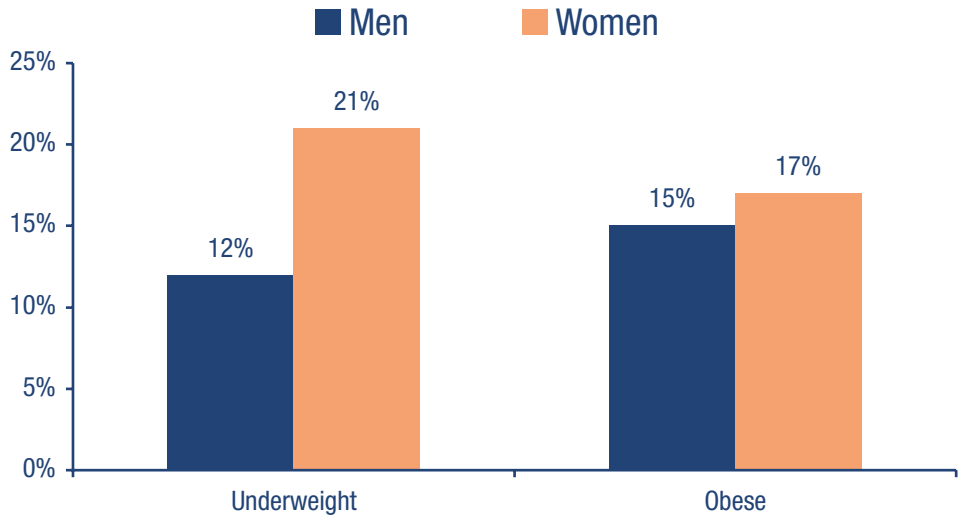
* Below recommended minimum number of servings

** More than 35% of calories

Source: Overview of Canadians' Eating Habits 2004.

- Access to a healthy diet depends partly on income. In 2000-01, 7% of seniors were living in households affected by **food insecurity** due to lack of money. *HungerCount 2005* reported that seniors accounted for 7% of food bank users in a typical month of 2005. By province, the highest percentage of seniors assisted by grocery programs was in Prince Edward Island (12.2%) and Nova Scotia (12%), followed by Alberta (10.4%) and New Brunswick (9.2%).
- **Obesity** has become a serious public health concern in Canada and other countries in recent years. Studies have shown that mortality and functional limitation risks are higher among seniors who are obese (defined by those having a BMI of 30 or more). Obesity rates increased slightly between 2000-01 and 2005, from 14.5% to 16.1%. The largest increase was among women aged 65 to 74 (from 17% to 21%). The obesity rate among seniors over the age of 75 continues to be the lowest (12%). Among seniors, women are more likely to be obese than men (17% vs. 15%) (chart 1.2).

Chart 1.2 Prevalence of weight problems in seniors, by sex, 2005



Note: Underweight = BMI less than 22; Obese = BMI of 30 and more.

Source: CCHS data analyzed by PHAC.

- In 2003, 8% of seniors suffered **injuries** that resulted in limitations.[10] Women aged 75 and over are at greater risk of sustaining injuries, with an injury rate of 10%.

[10] Versus 7% in 1998-99, although the difference is not statistically significant.

- Injuries resulting from **falls** can have a disastrous impact on the health and autonomy of seniors. In 2003, 5% of the senior population experienced a fall. Between 1998-99 and 2002-03, the annual **rate of hospitalizations due to falls** remained stable at approximately 16 per 1,000. The rate was higher among women aged 85 or more, rising to 46 per 1,000 in 2002-03.
- Falls often result in **fear of falling**. A recent survey revealed that more than half of all respondents over the age of 65 worried about falling.[11] Of these, 60% reported that this concern had caused them to limit their physical activities, and 45%, that it had limited their social activities.
- The final indicator, **suicide rates**, is of particular concern in men. Between 2001 and 2003 there were, on average, 20 suicides per year, per 100,000 men aged 65 and over. This represents a slight (albeit statistically insignificant) decrease compared to the rate during the 1997-99 period (23 per 100,000). By comparison, the suicide rate among women was 4 per 100,000 per year, between 2001 and 2003.[12]
- Men over the age of 85 are still at greatest risk of committing suicide (30 per 100,000 per year between 2001 and 2003). This level is stable relative to the preceding period, but remains *higher* than the rates for younger men.

Priorities for action

Priorities for improving the health of seniors include:

- Improving chronic disease management (e.g., self-management and community supports to adopt healthier lifestyles)
- Improving personal health practices (e.g., physical activity and healthy eating)
- Strengthening prevention programs for falls and injuries
- Reducing suicide rates among older senior men (85 and over)

[11] 24% were very concerned and 32% were fairly concerned.
[12] This annual rate is unchanged from the 1997-99 period.

Data sources - Question 1*

- **Life expectancy at age 65:** CANSIM*, table 102-0511 and *Deaths 2003*, Statistics Canada, 2005. Cat. No. 84F0211XIE.
  http://www.statcan.ca/english/freepub/84F0211XIE/84F0211XIE2003000.pdf.
- **Dependence-free life expectancy at age 65:** "L'espérance de vie en santé chez les personnes âgées," Presentation by Laurent Martel and Alain Bélanger, Statistics Canada, June 2005.
- **Health expectancy at age 65:** CANSIM, table 102-0121.
- **Self-assessment of health:** Canadian Community Health Survey (CCHS) data analyzed by the Division of Aging and Seniors (DAS), Public Health Agency of Canada (PHAC).

  Aboriginal Peoples Survey 2001 — Initial findings: Well-being of the non-reserve Aboriginal population, Statistics Canada, 2003. Cat. No. 89-589-XIE.
  http://www.statcan.ca/english/freepub/89-589-XIE/pdf/89-589-XIE03001.pdf
- **Functional health:** CANSIM, table 105-0213, adjustments made by PHAC to exclude the non-response component.
  http://www.statcan.ca/english/freepub/82-221-XIE/2005002/hlthstatus/function1.htm#status
- **Arthritis or rheumatism:** CANSIM, table 105-0002 and CCHS data analyzed by PHAC.
  http://www.statcan.ca/english/freepub/82-221-XIE/2005002/hlthstatus/conditions2.htm
- **Diabetes:** CANSIM, table 105-0011 and CCHS data analyzed by PHAC.
  http://www.statcan.ca/english/freepub/82-221-XIE/2005002/hlthstatus/conditions2.htm
- **Hypertension:** CANSIM, table 105-0010.
  http://www.statcan.ca/english/freepub/82-221-XIE/2005002/hlthstatus/conditions2.htm
- **Heart disease:** CCHS data analyzed by PHAC.
- **Chronic pain or discomfort:** CANSIM, table 105-0004.
  http://www.statcan.ca/english/freepub/82-221-XIE/2005002/hlthstatus/conditions2.htm#severity
- **ADL:** CCHS data analyzed by PHAC.
- **IADL:** CCHS data analyzed by PHAC.
- **Disabilities:** *A Profile of Disability in Canada, 2001 – Tables*, 2001 Participation and Activity Limitation Survey, Statistics Canada, 2002. Cat. No. 89-579-XIE.
  http://www.statcan.ca/english/freepub/89-579-XIE/89-579-XIE2002001.pdf
- **Physical activity:** CCHS data analyzed by PHAC and *Overview of the Time Use of Canadians*, 2005 General Social Survey on Time Use, Statistics Canada, 2006. Cat. No. 12F0080XIE.
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  http://www.statcan.ca/english/freepub/82-221-XIE/2005002/nonmed/behaviours1.htm#smoke
  http://www.statcan.ca/english/research/82-621-XIE/2005001/tables.htm#tables

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* For more information on the surveys used, visit: http://www.statcan.ca/english/concepts/index.htm
* CANSIM is Statistics Canada's key socio-economic database accessible through the Internet. For more information, go to www.statcan.ca

- **Nutrition:** Garriguet, D. *Overview of Canadians' Eating Habits 2004*, Findings from the Canadian Community Health Survey, Statistics Canada, 2006. Cat. No. 82-620-MIE – No.2. http://www.statcan.ca/english/research/82-620-MIE/82-620-MIE2006002.pdf
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  HungerCount 2005, Canadian Association of Food Banks, 2006. http://www.cafb-acba.ca/documents/HC05-eng.pdf
- **Injuries:** CANSIM, tables 104-0018 and 105-0218. http://www.statcan.ca/english/freepub/82-221-XIE/2005002/hlthstatus/conditions5.htm
- **Falls:** CCHS data analyzed by PHAC.
- **Fear of falling:** *Health Canada In-house Topline Analysis of Fall Questions Place on Environics' Focus 50+*, Environics, 2005 (unpublished).
- **Hospitalization due to falls:** *Report on Seniors' Falls in Canada*, Public Health Agency of Canada, 2005. http://www.phac-aspc.gc.ca/seniors-aines/pubs/seniors_falls/pdf/seniors-falls_e.pdf
- **Hospitalization for hip fracture:** *Health Indicators Reports*, Canadian Institute for Health Information, 2006. http://www.cihi.ca/hireports/search.jspa?language=en&healthIndicatorSelection=HipF
- **Obesity:** CCHS data analyzed by PHAC.
- **Underweight:** CCHS data analyzed by PHAC.
- **Oral health:** CCHS data analyzed by PHAC.
- **Self-assessment of mental health:** CCHS data analyzed by PHAC.
- **Suicide:** Analysis done by PHAC based on CANSIM, table 102-0540 and *Annual Demographic Statistics, 2003*, Statistics Canada, 2003. Cat. No. 91-213.

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Question 2: How is the health care system serving seniors?

Overview

Access to quality health care services is important for all Canadians but it is particularly important for Canadian seniors. Health care services can help prevent seniors' health problems, promote and restore health and prevent further decline. This chapter examines the use of health care services relying on selected indicators that measured seniors' access to family physicians and dental professionals as well as their levels of medication use and influenza immunization. To measure seniors' access to health care services, unmet health care needs, access to specialized care and length of waiting times are examined. Some seniors incur significant out-of-pocket expenses each year on health care. Insurance coverage and out-of-pocket expenses on health care and prescription drugs were used to determine the extent to which these extra costs detract from seniors' receiving appropriate health care insurance. To complete the picture, home care and long-term care use, as well as overall satisfaction with the quality of services, are discussed.

About the information

- Compared to the 2001 edition, the *2006 Report Card* was able to access more detailed information to determine how well the health care system is serving Canadian seniors. However, the available data still do not provide answers to some of the questions posed in the *2001 Report Card*. For example:
    - Are some services or practices being overused or underused?
    - How satisfied are seniors with the accessibility to and continuity of care?
    - When receiving care, how satisfied are seniors with the amount of time the care provider spends with them, the clarity of communication and the respect they are shown by the provider?
- Improvements in national data availability are still required to evaluate end-of-life care, and accessibility and quality of both home care and long-term care.
- As a result of improved data, this Report Card offers an improved understanding of the impact of waiting times on seniors. Also, new information on unmet home care needs represents an important addition.
- As a rule, whenever possible, data from the 2000-01 Canadian Community Health Survey were compared to those of the 2005 Survey (January-June).

- Due to data limitations, no grade was assigned to the indicator used to evaluate out-of-pocket expenses on prescription drugs.

Report

GRADE: C +

In terms of health care use and access, the vast majority of seniors report having regular access to a family physician and increasing visits with dental professionals. Seniors use more medications than in the past and have fairly high rates of immunization against influenza, though increases have recently levelled off. There remains a significant shortage of geriatricians in Canada to serve the country's aging population.

Fewer seniors are reporting unmet health care needs than in the past. This positive trend is also true of seniors' access to some types of specialized care. Waiting times for certain procedures (e.g., non-emergency surgery, diagnostic tests) have stabilized. Of course, given the concern over lengthy waiting times, this "stabilizing" of wait times, in fact, represents a lack of progress. This is a disappointment, particularly with respect to the length of time seniors must wait to see a medical specialist concerning a new medical condition. Medical insurance rates for seniors is increasing – a positive trend, but their out-of-pocket expenses on health care continue to rise. Not surprisingly, seniors continue to spend more on prescription drugs than other age groups though these amounts have stabilized recently.

Seniors are using less government-funded home care than in the past; about four percent report having unmet home care needs. A lower percentage of older seniors are living in health care institutions. Providing waiting lists are not an impediment to accessing an institution, this is a positive development. Finally, seniors' overall assessment of the quality of the health care services they receive is very high.

Summary table – Question 2

Topic	Indicators	Reference period	Trend direction	Grade
Health care use	Percentage of seniors with a regular family doctor	2001 and 2005	Stable	B
	Contact with dental professionals	1998-99 and 2003	Improving	C
	Medication use	1998-99 and 2003	Mixed trends	C
	Flu shots	2000-01 and 2003	Stable	B
Access to health care	Unmet health care needs	2000-01 and 2005	Improving	C
	Access to specialized care	2001 and 2005	Improving	C
	Waiting time	2001 and 2005	Stable	C
Insurance and expenses	Insurance coverage and 2003	1998-99	Improving	C
	Out-of-pocket expenses on health care	1999 to 2003	Worsening	C
	Out-of-pocket expenses on prescription drugs	1999 to 2003	Unknown	—
Home and continuing care	Home care use	1998-99 and 2003	Unknown	—
	Unmet home care needs	2003	Unknown	C
	Percentage of seniors living in health care institutions	1996 and 2001	Stable/ Improving for 85+	B
Satisfaction	Quality of hospital care services received	2000-01 and 2003	Stable	A
	Quality of family doctor or other physician care received		Worsening	B

Strengths

- A high percentage of seniors have a **regular family doctor**. This percentage increased slightly between 2000-01 and 2005, from 94% to 95%. The fact that the vast majority of seniors have regular access to a family doctor is very positive (Canadians without a regular family physician are more than twice as likely to report difficulties accessing routine health care compared to those having a regular family physician). Seniors are also more likely than younger Canadians to have received care from a physician in the last twelve months.

The need for geriatricians

In the *2003 Interim Report Card*, NACA expressed its concern with the inadequate number of geriatricians (i.e., those trained in geriatric medicine) in Canada. This concern remains. In 2000, there were 144 geriatricians in Canada, although an estimated 481 were needed. By 2005, there were 191 geriatricians. This is a significant improvement but certainly insufficient when compared to the estimated 538 geriatricians needed in 2006.

Source: Hogan, D.B, Shea, C. and C. Frank. *Education of Specialists in the care of older individuals.*

- Dental health has a very important role in overall health maintenance and prevention of disease, particularly for seniors. Seniors' **contact with dental professionals** increased significantly between 1998-99 (40%) and 2003 (46%).[13]
- Seniors are using more **medications** than in the past. In 2003, 92% of seniors used medication in the previous month compared to 88.5% in 1998-99. This increase is highest among senior men. With the exception of medications for hormones to treat menopause and aging symptoms among women, use of all classes of medications increased between 1996-97 and 2003. Though there are likely exceptions, this increased medication use among seniors is probably a positive development as it may be indicative of improved diagnosis of various diseases, together with improved treatment capacity of medications.
- National targets for **influenza immunization** for seniors were 70%, to be reached by 2000-01. Immunization rates for seniors have almost reached this target. In 2003, 67% of seniors were immunized – almost unchanged from the 2000-01 rate – but a substantial increase from 51% in 1996-97.
- As a key indicator of access to care, "**unmet health care needs**" is defined as the difference between health care services deemed necessary to address a particular health problem and the actual services received. Fewer seniors reported unmet health care needs in 2005 compared to 2000-01 (6.6% vs. 8.4%). In 2005, almost half of unmet needs were attributable to long waiting times. Unmet needs decreased with age, from 14% for Canadians aged 35-44 to 6% over the age of 75 in 2005.
- In 2005, seniors were less likely to report difficulties in **accessing specialized care** than they were in 2000-01. This improvement in access was particularly true for non-emergency surgery (10% vs. 14%) or receiving a diagnostic test (8% vs. 13%), but was less true for seeing a medical specialist for a new condition (20% vs. 21%).

[13] Dental professionals include dentists, orthodontists or dental hygienists.

- Although median **wait times** for seniors accessing specialized care showed no improvement between 2000-01 and 2005 (table 2.1), the median wait time was the same as the *acceptable* wait time for non-emergency surgery and diagnostic tests in 2005. The exception to this is the length of time required for seniors to access a medical specialist. In this case, the actual wait time is far longer than the acceptable one (4.3 vs. 2.0 weeks).

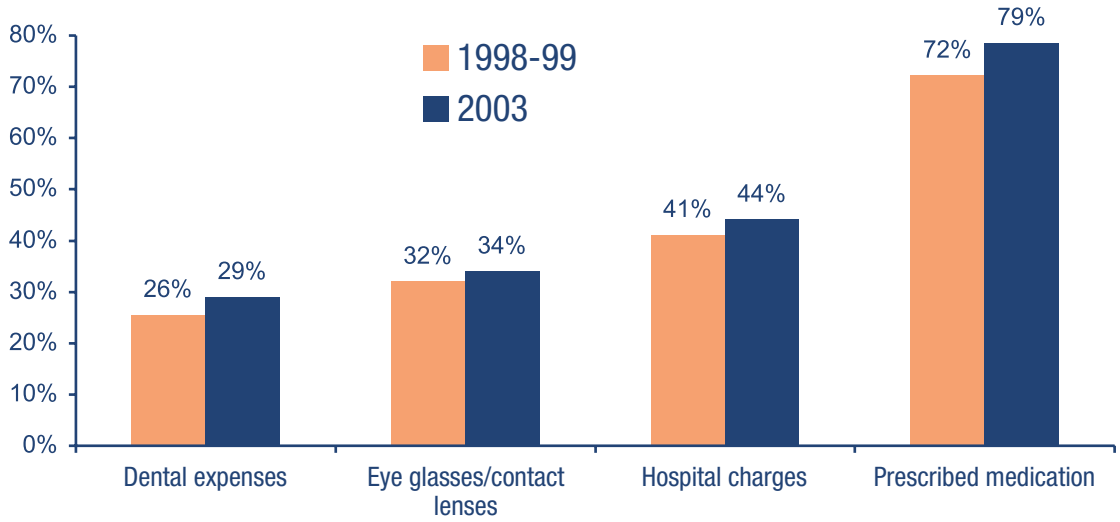
Table 2.1 Median wait time of seniors* (in weeks)

	Actual median wait time		Acceptable wait time
	2000-01	2005	2005
Medical specialist – for a new condition	4.0	4.3	2.0
Non-emergency surgery	4.3	4.3	4.3
Diagnostic test	2.0	2.0	2.0

*Based on population accessing specialized care in the past 12 months
Source: HSAS 2000-01 and 2005 data (January-June 2005) analyzed by PHAC.

- **Insurance coverage** for seniors increased between 1998-99 and 2003 for dental expenses, eye glasses/contact lenses, hospital charges and prescribed medications (chart 2.1).

Chart 2.1 Insurance coverage* increased for seniors between 1998-99 and 2003



* Refers to any private, government or employer-paid plan that covers all or part of the item.
Source: NPHS 1998-99 and CCHS 2.1 data analyzed by PHAC.

Home care

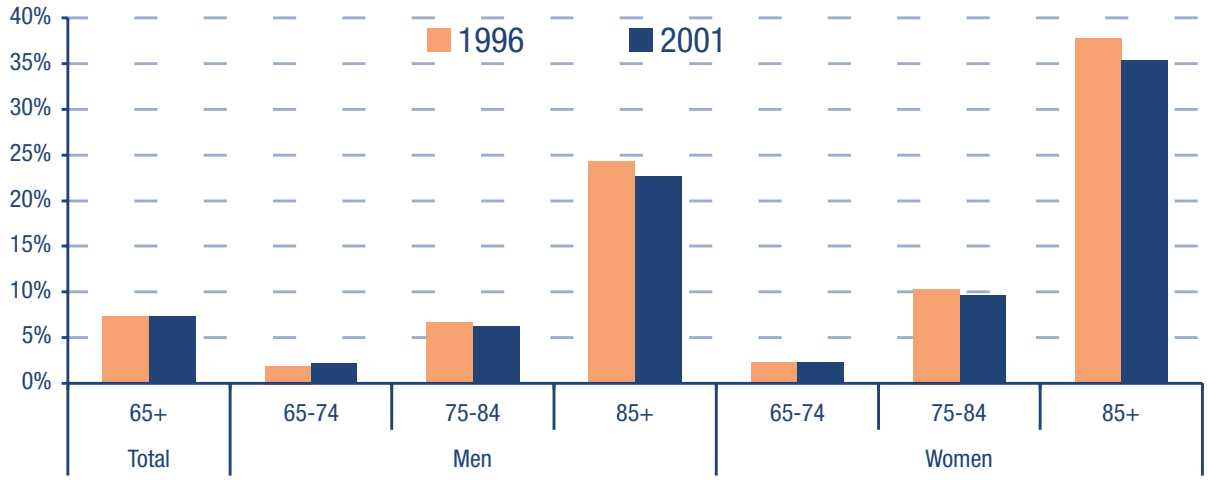
Seniors used less government-funded home care services in 2003 compared to 1998-99 (8.9% vs. 11.5%). However, it is difficult to determine whether this trend is negative, neutral or positive. For instance, did seniors require less home care or did they turn to non-government funded home care to fill the gap? Because there is no comparable data for non-government funded home care (i.e., 1998-99 – 2003), it is impossible to conclude whether a shift towards non-government funded home care took place during this period. Therefore, no grade has been assigned to this indicator.

In 2003, 15% of seniors reported receiving *some* level of home care services. Among them, 9% received formal care only (paid services, whether from government or non-government providers), 4% informal care only (non-paid assistance from friends or family) and 2% a combination of formal and informal care. The percentage of seniors receiving any home care rose from 8% at age 65 to 74 to 42% at age 85 and over. Reliance on formal caregiving suggests limited social networks.

Sources: Cranswick, K. and D. Thomas. *Elder Care and the Complexities of Social Networks.*
Rotterman, M. *Seniors' Health Care Use.*

- It is generally considered better to remain living in the community than to move to a long-term care institution. Fewer older seniors, especially those aged 85 and over, are **living in health care institutions** than in the past (chart 2.2).

Chart 2.2 A smaller percentage of seniors aged 75 and older lived in health care institutions in 2001 than in 1996



Note: Health care institutions include hospitals, nursing care homes, residences for senior citizens, and facilities for the disabled. A small proportion of seniors reside in other types of institutions, lodging and rooming houses, and religious establishments.

Sources: 1996 and 2001 Census. A Portrait of Seniors in Canada. Profile of Canadian families and households: Diversification continues.

- In the *Interim Report Card* published in 2003, NACA described under-funding in long-term care institutions as an area of concern. A very positive development has occurred in New Brunswick, where the province is reversing its policy of charging nursing home residents for

health care costs. The average cost of nursing home care in March 2006 was $160.00 per day. This amount will soon drop by more than 50%. It was also announced (October 2006) that Cabinet agreed to immediately remove seniors' homes, assets and life savings from the calculation of nursing home fees.

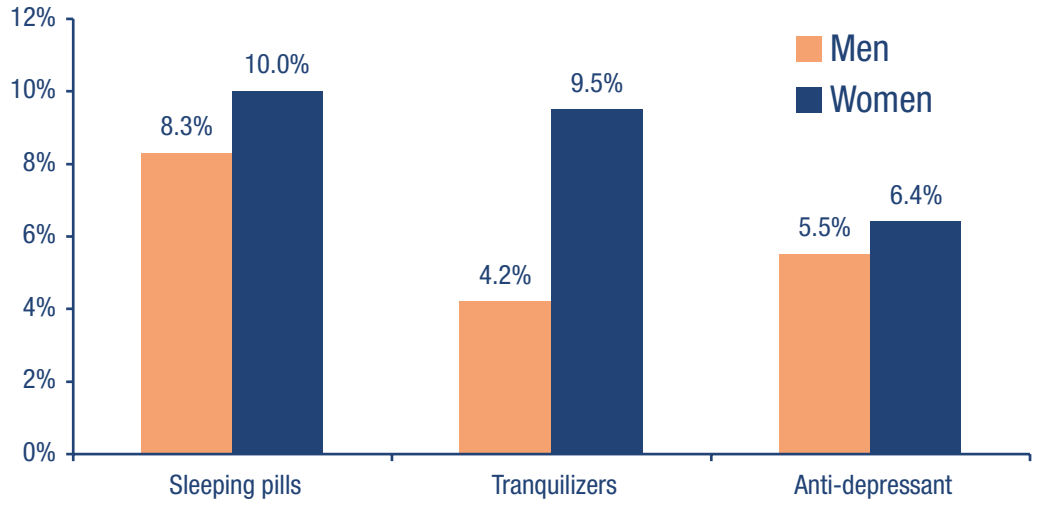
- Overall, seniors are highly satisfied with the **quality of health care services received** – whether hospital or physician care. In 2003, 90.3% of seniors rated the hospital health care services they received as excellent or good (almost unchanged from 2000-01). In the same year, 93.3% of seniors rated care by their family doctor or other physician as excellent or good – down slightly from 95.6% in 2000-01.

Weaknesses

- Seniors' rates of **contact with dental professionals**, though improving significantly, are still substantially lower than those of younger age groups. Moreover, there are major differences between provinces and territories: in 2003, 57% of Ontario seniors had contact with dental professionals, compared to only 18% in Newfoundland.
- In rural and remote areas, "lack of services is forcing seniors into long-term care facilities before they are ready or before it is necessary. These facilities are often at a distance from the home community, contributing to loneliness and depression."[14]
- Though increased **medication use** *can* be a positive development, depending on the context, this is generally not true of sleeping pills and tranquilizers. Between 1996-97 and 2003, seniors' use of sleeping pills increased (8% vs. 9%), as did their use of tranquilizers (5% vs. 7%). Senior women are more likely to use these drugs (chart 2.3).
- Conversely, seniors use anti-depressants at a lower rate than younger adults even though research demonstrates that depression is under-diagnosed among seniors and that most seniors who commit suicide suffer from depression.

[14] McCracken, M. et al. *Seniors in Rural and Remote Canada: Position Paper*. Advisory Committee on Rural Issues for the Canadian Rural Partnership. April 2005. Online: http://www.rural.gc.ca/acri/seniors_e.phtml

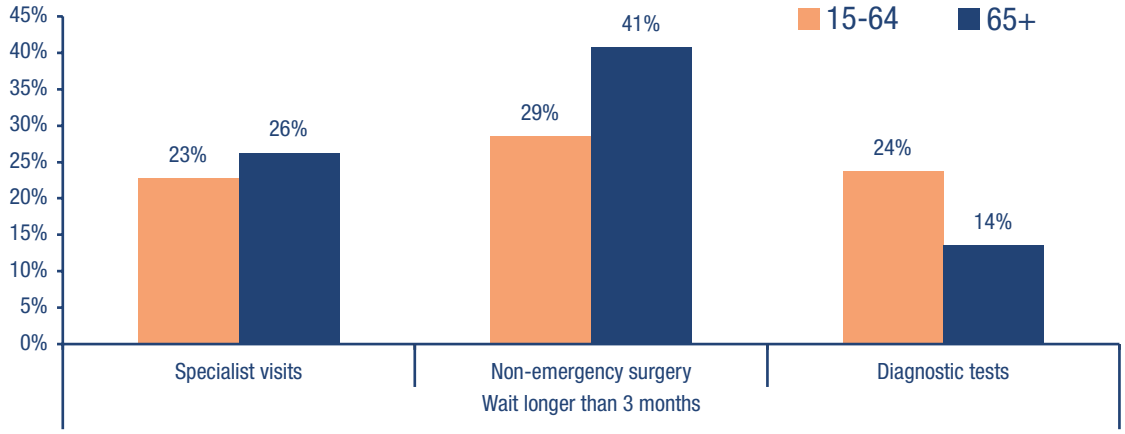
Chart 2.3 Senior women are more likely to use sleeping pills and tranquilizers, 2003



Source: Portrait of Seniors and CCHS data analyzed by PHAC.

- Low-income seniors reported a much higher level of **unmet health care needs** than did seniors with middle or high income (9% vs. 6% in 2005).
- Regarding **wait times**, the percentage of seniors who waited longer than three months for specialist visits and non-emergency surgery was greater than for Canadians aged 15 to 64 (chart 2.4).

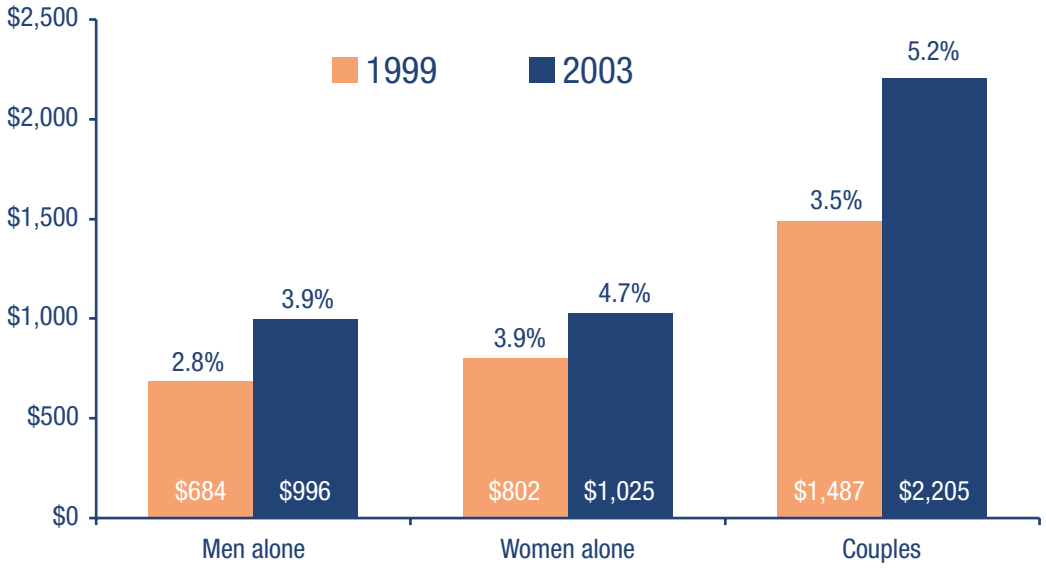
Chart 2.4 More seniors than other age groups wait longer than 3 months for specialist visits and non-emergency surgery, 2005



Source: DAS analysis of HSAS 2005 (January-June 2005).

- Concerning acceptable **waiting times**, about one quarter of the seniors who needed to see a medical specialist for a new condition in 2005 reported that their wait time was unacceptable. For their most recent non-emergency surgery and their most recent diagnostic test respectively, 19% and 15% of those who underwent these procedures waited longer than what they considered acceptable.
- Compared to other adult populations, seniors have less **insurance** for health care services; the exception to this is prescription drug coverage where seniors are more insured. Among seniors, insurance coverage is lower for women, those aged 75+, those with low incomes, and immigrant seniors (again, the exception to this trend is insurance for medication, where there is no difference).
- **Out-of-pocket health care expenditures** for senior households increased significantly between 1999 and 2003, both in constant dollars and as a percentage of seniors' incomes (chart 2.5).

Chart 2.5 Average out-of-pocket health care expenditures for senior households, 1999 and 2003 (2003 constant $ and % of income)



Sources: Spending Patterns in Canada, with adjustments by DAS using PCI for health expenditures. *Income in Canada, 2003.*

- Even though **out-of-pocket spending** on prescription drugs represented the largest percentage of all out-of-pocket health care spending by seniors (2002), it still represented, on average, only about 1.5% of seniors' after-tax income.
- In 2003, 3.6% of seniors reported having **unmet home care needs**. Among these seniors, more than 20% reported availability problems and more than 20% reported cost problems.

National home care indicators

In the future, the Home Care Reporting System (HCRS) will provide comparative reports and analysis relating to clients who receive publicly-funded home care. A National Pilot Test provided an illustration of indicators for the health system, such as waiting times, service hours, and use of emergency care services.

Ontario, Nova Scotia, British Columbia, Alberta, Saskatchewan and Yukon have home care management initiatives underway.

Source: Canadian Institute for Health Information. *Development of National Indicators and Reports for Home Care, PhaseII — Final Project Report.*

Priorities for action

Priorities for improving the health care system to better serve seniors include:

- Reducing median wait times for seniors' access to specialized care
- Reducing out-of-pocket spending on health care by seniors
- Developing new indicators and data to better measure:
  - the number of full-time equivalent geriatricians in Canada;
  - the funding, waiting lists and care in long-term care institutions;
  - national home care delivery; and
  - palliative and end-of-life care

Data sources - Question 2*

- **Regular family doctor:** CCHS data analyzed by PHAC and *The Daily*, Statistics Canada, February 13, 2006.
  http://www.statcan.ca/Daily/English/060213/d060213a.htm
- **Contact with dental professionals:** CANSIM*, table 105-260.
  http://www.statcan.ca/english/freepub/82-221-XIE/2004002/community/system2.htm#medical
- **Medication Use:** National Population Health Survey (NPHS) and CCHS data analyzed by PHAC and Lindsay, C. *A Portrait of Seniors in Canada*, Third Edition, Statistics Canada, 1999. Cat. No. 85-519-XPE.
- **Flu shots:** Johansen, H., Sambell, C. and W. Zhao. Flu shots — National and provincial/territorial trends. *Health Reports,* vol. 17, no. 2, May 2006. pp. 43-48.
- **Unmet health care needs:** CCHS data analyzed by PHAC.
- **Access to specialized care:** Health Services Access Survey (HSAS) data analyzed by PHAC.
- **Waiting time:** HSAS data analyzed by PHAC.
- **Insurance coverage:** NPHS and CCHS data analyzed by PHAC.
- **Out-of-pocket expenses on health care:** *Spending Patterns in Canada*, Statistics Canada. Cat. No. 62-202-XIE, adjustments done by PHAC using PCI for health expenditures.
  http://www40.statcan.ca/l01/cst01/econ161a.htm?sdi=price%20consumer%20index
- **Out-of-pocket expenses on prescription drugs:** Luffman, J. Out-of-pocket spending on prescription drugs. *Perspectives on Labour and Income*, vol. 17, no. 4. September 2005. Cat. No. 75-001-XIE. pp. 5-13.

  Income in Canada 2002, Statistics Canada, 2004. Cat. No. 75-202-XIE-2002000.
- **Home care use:** CCHS data analyzed by PHAC.
- **Unmet home care needs:** CCHS data analyzed by PHAC.
- **Seniors living in health care institutions:** Lindsay, C. *A Portrait of Seniors in Canada*, Third Edition, Statistics Canada, 1999. Cat. No. 85-519-XPE.

  Profile of Canadian families and households: Diversification continues, Statistics Canada, 2002. Cat. No. 96F0030XIE2001003.
  http://www12.statcan.ca/english/census01/products/analytic/companion/fam/pdf/96F0030XIE2001003.pdf
- **Quality of care services:** CANSIM, tables 105-0281, 105-0081, 105-0282 and 105-0082.

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* For more information on the surveys used, visit: http://www.statcan.ca/english/concepts/index.htm
* CANSIM is Statistics Canada's key socio-economic database accessible through the Internet. For more information, go to www.statcan.ca

References - Question 2

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Canadian Institute for Health Information. *Development of National Indicators and Reports for Home Care, Phase II — Final Project Report.* Ottawa, 2004.

Cranswick, K. and D. Thomas. Elder Care and the Complexities of Social Networks. *Canadian Social Trends*, No. 77, Summer 2005. Cat. No. 11-008. pp.10-15.

Hogan, D.B, Shea, C. and C. Frank. Education of Specialists in the care of older individuals, *The Canadian Journal of Geriatrics*, vol. 9, supp. 1, 2006. pp. S19-S26.

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Sanmartin, C. et al. *Access to health care services in Canada, 2001*. Statistics Canada, 2002. Cat. No. 82-575-XIE.
http://www.statcan.ca/english/freepub/82-575-XIE/82-575-XIE2002001.pdf

Question 3: How well are seniors faring economically?

Overview

Seniors' economic status is important to their quality of life in a variety of ways. Income plays a role in determining seniors' physical and mental health, their life expectancy, the quality of their housing and many other aspects of well-being. Personal income and wealth likely influence how a senior participates in society.

Several indicators offer information on seniors' economic status. The most important are those describing directly seniors' incomes, but those identifying the source and distribution of these incomes are also revealing. Finally, an examination of the trends related to low income, the uptake of various government income supplement programs and seniors' own perception of their financial status complete the picture.

About the information

- The statistics on income in this section refer generally to *after-tax* income because it more accurately reflects purchasing power. *Before-tax* income statistics are not as precise – nor are any conclusions drawn from such statistics – because they do not reflect an individual's actual disposable income. For this reason, the summary table clearly indicates the rare cases where *before-tax* income statistics have been used. To neutralize the effects of inflation, income is expressed in constant dollars – which allows for meaningful comparisons between different periods of time.
- Both mean and median incomes are presented. The median income divides the population in two: one half of all incomes will fall below the median; the other half will be greater than the median. Median income better reflects income distribution since mean income (i.e., average) may be "skewed" by extremes at both ends of the statistics.
- Canada has no agreed-upon definition of *low income* or *poverty*. For the purposes of this document, NACA used the after-tax *low income cut-off* (LICO) to indicate economic vulnerability. There are 35 different LICOs across the country, based on the cost of food, clothing and shelter for a given region and a given family size; these LICOs are updated annually. People who spend 20% more of their income on basics than the average family are considered as living under the LICO.

- The *2006 Report Card* includes three new indicators related to Guaranteed Income Supplement (GIS) recipients: the percentage of seniors receiving GIS, the number of persons who are *eligible* for GIS but do not collect it (these data were previously unavailable), and estimates of the number of applicants who fail to renew their GIS application in time and are therefore temporarily cut off from this income source.[15]

Report

GRADE: B

Since the publication of the *2001 Report Card*, the overall economic status of seniors has improved: the average senior's income increased; a smaller percentage of seniors have low income; and the percentage of seniors who rely heavily on Old Age Security/GIS has decreased. Yet, not all trends related to seniors' incomes have been positive. For example, the income gap between men and women has remained constant since 2000. Moreover, many regional differences remain and certain sub-populations continue to live below the LICO. Senior women, older seniors (75 and older) and recent immigrants are more likely to live on low income than other Canadian seniors. In the *2001 Report Card*, NACA identified the economic status of unattached seniors, particularly women, as an area for priority action. Five years later, despite an increase in their incomes, unattached women are still very much at risk of living below the LICOs. This report also provides some information on the relative economic situation of separated, divorced and widowed women.

[15] Every year, GIS recipients must re-apply for their benefits. If they fail to do so in time, or if their income is too high to qualify them, they receive only OAS, starting in July of that year.

Summary table – Question 3

Topic	Indicators	Reference period	Trend direction	Grade
Income	Mean and median income of seniors, by family type	2000-04	Improving	B
	Median income of seniors compared to non-seniors	2000-04	Mixed trends	B
	Gap in mean income between men and women *(before-tax)*	2000-04	Stable	C
Source of income	Percentage of income from public and private pension plans, OAS and other sources *(before-tax)*	1999 and 2003	Improving	B
Income distribution	Distribution of seniors' income *(before-tax)*	1999 to 2003	Improving	B
Low income	Percentage of seniors below the LICOs	2000-04	Improving	B
	Persistence of low income	1996-2001 and 1999-2004	Improving	A
Guaranteed Income Supplement (GIS)	Percentage of seniors receiving GIS	1999 to 2004	Improving	B
	Number of seniors eligible for GIS but who do not receive it	1999-2001 and 2003	Improving	B
	Number of seniors applying late for GIS	2000-05	Worsening	C
Assets and debts	Financial and non-financial assets	No new data	Unknown	—
	Indebtedness			
Economic well-being	Perception of financial situation after retirement	2002	Unknown	—

Note: Except where clearly stated, statistics refer to *after-tax* income, expressed in constant dollars.

Strengths

Between 2000 and 2004, both **mean income** and **median income** of unattached seniors and senior families increased (table 3.1). The median income increased by 7 percentage points for senior families and unattached women and by 10 percentage points for unattached men. In 2004, the median income for senior families was $38,500; for unattached men, $21,300; and for unattached women, $19,000.

Table 3.1 Both mean and median income increased for main family types between 2000 and 2004 (constant 2004 dollars)

	Mean income			Median income		
	Senior families	Unattached men	Unattached women	Senior families	Unattached men	Unattached women
2000	$42,600	$23,600	$21,100	$36,000	$19,300	$17,800
2004	$45,400	$25,600	$23,200	$38,500	$21,300	$19,000
Changes	+ $2,800	+ $2,000	+ $2,100	+ $2,500	+ $2,000	+$1,200

Source: Income in Canada, 2004.

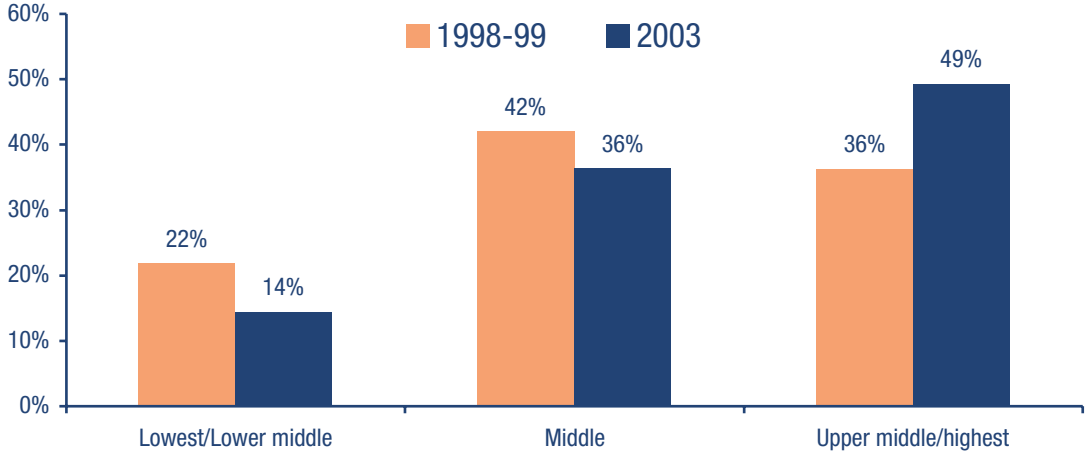
Seniors' perception of their financial situation

The majority of seniors (55%) believe that their **financial situation** remained unchanged after they retired from the paid labour force. Seniors who believe that their financial situation has worsened since their retirement are slightly more numerous than those who believe that their financial situation has improved (25% vs. 20%). A study shows that recent retirees whose financial situation has improved since retirement and those receiving pension income were most likely to also report an increase in their enjoyment of life.

Sources: GSS 2002, data analyzed by PHAC.
Canadian Social Trends, Autumn 2005.

- Regarding seniors' **sources of income**, the nature of the changes reported in the *2001 Report Card* continued between 1999 and 2003. Of interest, is the increased importance of private pension plans (from 29% to 34%) and the decrease in the share of seniors' incomes from OAS/GIS (from 27% to 25%). Incomes associated with private pension plans are indicative of higher retirement income levels. Conversely, most low-income seniors depend exclusively on public income security programs (i.e., OAS/GIS and CPP/QPP).
- The majority (60%) of seniors who are **beneficiaries of private pension plans** report that their benefits are indexed to the cost of living; 9% report that they are partially indexed.
- An examination of the **distribution of income** reveals that a smaller percentage of seniors were among the poorest in 2003, compared to 1998-99 (14% vs. 22% – see chart 3.1). This distribution also held true for senior women and seniors of both genders over 75 years of age. This is a positive development as it indicates that income increased for these most vulnerable populations.

Chart 3.1 Fewer seniors are in the lowest income category and more seniors are in the highest income category



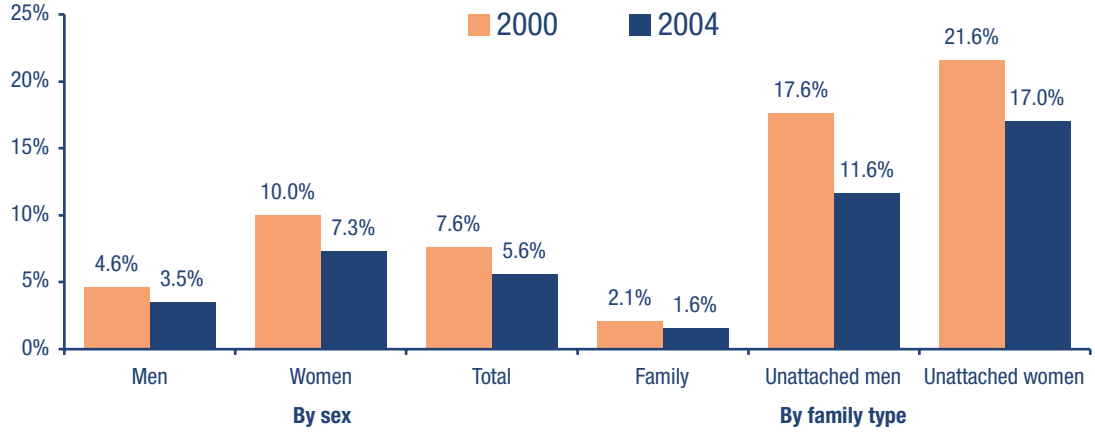
Distribution of Seniors by *Before-Tax* Household Income, 1998-99 and 2003

Note: Income categories are based on the income and the size of the households.

Source: NPHS 1998-99 and CCHS 2.1 data analyzed by PHAC.

- Compared to other Canadians, seniors are less likely to live below the *after-tax* **low income cut-offs** (LICOs). In 2004, 5.6% of seniors were below the LICOs (3.5% of men and 7.3% of women), which is much lower than the corresponding rate for all Canadians: 11.2%. While the low income rate is higher among senior women, there was a further reduction (by 2.7 percentage points) between 2000 and 2004 (chart 3.2). There was also a reduction in the low income rate of unattached seniors, by about 5 percentage points.

Chart 3.2 Unattached seniors are more likely to live below the after-tax LICOs



Source: Income in Canada, 2004.

- Between 1999 and 2004, the percentage of **seniors receiving the GIS** has decreased slightly, from 37% to 35%. The most significant decrease was for seniors over 80 years of age. This downward trend was observed in all provinces during the 1990s.
- As a result of efforts made by Human Resources and Social Development Canada (HRSDC), the annual number of persons **eligible to receive the GIS but who did not receive it** *decreased* by 34%, from 206,800 between 1999-2001 to 137,000 in 2003.
- The 2005 federal budget provided funding for increasing the **GIS benefit rates**, by 7% over two years, beginning in 2006. This benefit increased by $18 a month for single recipients and by $29 a month for couples in January 2006. It will increase by the same amount again in January 2007.
- **Persistence of low income** (i.e., duration) also decreased for seniors. Between 1999 and 2004, only 1.8% of seniors remained under the low-income cut-offs for six years in a row. This rate is much lower than it was for seniors during 1993-98 (3.3%) and lower than the rates for other Canadians aged 25 and over, especially those aged 55 to 64 years.

Weaknesses

- Data related to the **mean and median income** mask regional differences. For example, seniors living in Quebec, in the Atlantic provinces, in the Northwest Territories and in Nunavut have lower incomes. Further, not all Canadian seniors face the same **cost of living**: remote areas and large urban centres often have higher costs of living.
- **Recently immigrated seniors** are more likely to have low incomes. Due to the 10-year residency requirement to qualify for OAS and GIS, they must manage without these government benefits.
- As mentioned earlier, compared to younger Canadians, seniors are less likely to live below LICOs. However, after a long period of "catching-up," the **income gap is generally increasing**[16] between seniors and non-seniors. The gap between senior families' median incomes versus non-seniors families increased from $18,300 to $19,100 between 2000 and 2004. In 2000, unattached senior women had median incomes which were $200 higher than non-senior unattached women; five years later their income was $1,100 lower than their non-senior counterparts. Drawing conclusions from income gaps between seniors and non-seniors must take into account the fact that seniors' assets are often higher than those of non-seniors, and that their expenses and debts are generally lower (e.g., no mortgage, lower tax bracket than when they were in the paid labour force). Thus, even though they are likely to have higher medical expenses than younger Canadians, seniors can often have a lower income than younger people yet enjoy the same standard of living.
- The **income gap between genders** is still very evident. In 2004, the mean *before-tax* income of women over 65 was 67% of that of men. The constant before-tax income difference between men and women in 2004 was $10,800 ($21,400 vs. $32,500), virtually unchanged from 2000.

[16] An exception occurred with unattached men: between 2000 and 2004, the median income gap between senior and non-senior unattached men decreased (from $4,500 to $2,900).

Senior women have lower incomes

Older women tend to have lower incomes than men because they participated less in the paid labour force, and if they were employed, their wages were less, on average. In 2004, about one in five senior women had never worked outside the home. Further, because women live longer, they are at greater risk of running out of savings over their lifetimes.

According to a new study, senior women suffer much more financially from widowhood than do senior men. Over a 10-year period, senior widows saw their income decrease in the five years after the death of their husband, while widowers' income increased in the five years after the loss of their wife.

Sources: Women in Canada 2005.
The Daily, July 10, 2006.

- Less than 50% of seniors benefit from a **private pension plan**. Receiving income from private pension plans largely remains a benefit of men and non-immigrants. In 2003, these plans represented 41% of men's incomes but only 26% of women's. Most divorced women do not claim a portion of their former spouse's pension despite being entitled to it. In 2003, only 12% of immigrants aged 60 or older reported private pension income; this pension money accounted for only 13% of their total income.
- Women are far more likely to depend on OAS and GIS as important **sources of income**. In 2003, these two programs accounted for 32% of women's income, compared to only 18% of men's income. Among seniors with the lowest income, two thirds of their incomes came from OAS.
- Statistics Canada estimates that 219,000 seniors were living below the **LICOs** in 2004. More than 60% of these low income seniors were unattached senior women. Among unattached elderly women, the incidence of low income is particularly high among the separated and the divorced, followed by the widowed. Never-married elderly women fare better than these subgroups but are still less well off, relative to common-law and married women.[17]
- Reliance on the **GIS** remains high in certain provinces and territories like Newfoundland and Labrador, the Northwest Territories and Nunavut, where more than 60% of seniors received this source of income in 2000. In addition, close to one half of women over the age of 80 depended on the GIS (2004). In 2003, 63% of immigrant seniors who had met the residency requirement reported GIS income.
- Unfortunately, the **GIS** is sometimes insufficient to allow seniors – especially those who are unattached – to live above the **LICOs**. In 2004, an unattached person who received only the OAS and the GIS had an annual income of $12,239 – an amount less than the LICO for urban areas.[18]
- The 137,000 seniors who, in 2003, were **eligible for the GIS but who did not receive it**, represented 3% of the seniors' population. The value of these forgone supplements was estimated to be $204 million in 2003. These seniors also forfeited all other benefits provided by provinces or territories that use the status of GIS recipient as an eligibility criterion.

[17] NACA. *Aging in poverty in Canada.*
[18] Source: Human Resources and Social Development, Forecasting, Information and Analysis.

Uncoordinated income-based programs

Low income seniors must deal with a multitude of uncoordinated federal and provincial/territorial income-based programs. Because of the claw-back component of GIS and the use of GIS recipient status as a criterion for receiving other benefits, even a modest increase in income can affect GIS and other benefits and increase costs and taxes. For example, a person receiving the GIS who cashes a $1,000 RRSP could see his/her GIS benefits reduced by $500. If this person is among the 50% of GIS recipients who pay income tax, he/she could also pay a further $250 in income tax. Finally, other benefits such as provincial/territorial income supplements and/or subsidized housing may also be reduced or eliminated.

In the worst-case scenario, the cumulative effects of additional income may well be a net loss of income. Seniors with low income are trapped. Due to the disincentives mentioned, they are discouraged from earning additional income to make their lives more enjoyable.

Source: NACA. *Aging in poverty in Canada.*

- Each July, people who have not re-applied for their GIS benefit are suspended from receiving benefits until renewal applications are completed. In 2005, there were approximately 115,000 **late applicants to GIS** (compared to about 65,000 in 2000). This increase also holds true in relative terms, as the percentage of late applicants rose from 4.7% to 7.4% between 2000 and 2005. While death, increase in income and changes in marital status can account for some of these statistics, NACA believes that most of the decrease in GIS uptake each July may be explained by failure to follow the required renewal procedure.

Priorities for action

Priorities for improving the economic situation of seniors include:

- Increasing the GIS so that the combined GIS and OAS benefits are equal to or greater than the LICO
- Correcting GIS shortcomings (e.g., increase uptake, decrease the number of late applicants and not unduly penalize them)
- Improving coordination of income-based programs
- Ensuring automatic and compulsory sharing of pension rights under the Canada Pension Plan, employer pension funds, and retirement savings plans following divorce or legal separation

Data sources - Question 3*

- **Mean and median income of seniors:** CANSIM*, Table 111-035.
  Income in Canada 2004, Statistics Canada, 2006. Cat. No. 75-202-XIE-2004000.
  http://www.statcan.ca/english/freepub/75-202-XIE/75-202-XIE2004000.pdf
- **Median income of seniors compared to non-seniors:** *Income in Canada 2004*, Statistics Canada, 2006. Cat. No. 75-202-XIE-2004000.
  http://www.statcan.ca/english/freepub/75-202-XIE/75-202-XIE2004000.pdf

  Survey of financial security and Survey of household spending.
- **Gap in mean income between men and women:** CANSIM, table 202-0407.
- **Source of income:** *Canada's Retirement Income Programs: A Statistical Overview (1990-2000)*, Statistics Canada, 2003. Cat. No. 74-507-XIE.

  Women in Canada: *A gender-based statistical report*, Fifth edition, Statistics Canada, 2006. Cat. No. 89-503-XPE.
- **Beneficiaries of private pension plans:** General Social Survey (GSS) 2002 data analyzed by PHAC.
- **Distribution of seniors' income:** NPHS and CCHS data analyzed by PHAC.
- **Seniors below the low-income cut-offs (LICOs):** *Income in Canada 2004*, Statistics Canada, 2006. Cat. No. 75-202-XIE-2004000.
  http://www.statcan.ca/english/freepub/75-202-XIE/75-202-XIE2004000.pdf
- **Persistence of low income:** CANSIM, Table 202-0807.
  Income in Canada 2004, Statistics Canada, 2006. Cat. No. 75-202-XIE-2004000.
  http://www.statcan.ca/english/freepub/75-202-XIE/75-202-XIE2004000.pdf
- **Percentage of seniors receiving GIS:** *Canada's Retirement Income Programs (1990-2000)*, Statistics Canada, 2003. Cat. No. 74-507-XIE.
- **Number of seniors eligible for GIS but who do not receive it:** Poon, P. Who's missing out on GIS? *Perspectives on Labour and Income*, October 2005. Cat. No. 75-001-XIE. pp. 5-14.

  Human Resources and Social Development, Forecasting, Information and Analysis, GIS Take-up, 1993-2003. Special compilation done by Statistics Canada using the Longitudinal Administrative Databank (LAD).
- **Number of seniors applying late for GIS:** Social Development Canada. *Canada Pension Plan and Old Age Security – Monthly Statistical Bulletins,* 2002 to 2005. For 2000 and 2001, data were obtained directly from Social Development Canada.
- **Financial situation versus expectations prior to retirement:** GSS 2002 data analyzed by PHAC.

  Schellenberg, G. and C. Silver. You can't always get what you want: Retirement preferences and experiences. *Canadian Social Trends*, No. 75, Winter 2004. Cat. No. 11-008. pp. 2-7.

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* For more information on the surveys used, visit: http://www.statcan.ca/english/concepts/index.htm
* CANSIM is Statistics Canada's key socio-economic database accessible through the Internet. For more information, go to www.statcan.ca

References - Question 3

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http://socserv.socsci.mcmaster.ca/sedap/p/sedap104.pdf

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http://www.naca-ccnta.ca/margins/poverty/pdf/margins-poverty_e.pdf

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Question 4: What are seniors' living conditions?

Overview

Living conditions have a direct impact on seniors' mental and physical health and well-being. Those with available transportation and who live in safe, enabling environments that promote independence and socialization are more likely to live happier and healthier lives. Appropriate, accessible and affordable housing plays a central role in determining seniors' physical and financial security, as well as their independence. The ability to drive a vehicle, and/or the availability of other transportation alternatives, are critical for seniors to have access to services, recreation and to enjoy social contact.

To assess seniors' living conditions, this chapter examines living arrangements, housing, transportation and safety/criminal victimization. This edition also draws attention to the issue of homelessness.

About the information

- The data show that the percentage of seniors living alone is increasing, especially after the age of 85. It is difficult, however, to conclude whether this trend represents an *improving* or a *worsening* situation. This indicator generated a great deal of discussion among both experts and reviewers, since the degree to which this trend is due to personal choice is unknown. As a result, no grade for the indicator related to *living alone* has been provided. Both the positive and the negative interpretations of this indicator are explored.
- Two indicators describe housing problems: *housing affordability* (describes those who spend 30% or more of their before-tax income on shelter costs – some voluntarily, some out of necessity), and *core housing need* (describes households who out of necessity have to spend more than 30% of their before-tax income on shelter that meets adequacy, suitability, and affordability standards – standards that are adjusted over time to reflect the housing expectations of Canadians).
- Seniors' access to and use of public transportation is unknown. Only one new indicator provides additional information related to transportation: the *percentage of seniors with driving licenses.*
- Data on seniors' victimization are somewhat limited due to under-reporting. Statistics Canada data are based on a sub-set of police departments and only include those aged 65

to 89. For seniors' *victimization from fraud,* the statistics are limited to seniors' self-reporting to a national call centre (PhoneBusters); the data presented represent only a portion of possible fraud. For this reason, no grade was attributed to this indicator.

- No national data were found on the institutional abuse of seniors.

Report

GRADE: B

More Canadians are living alone than in the past and seniors are no exception. For some seniors, this trend is a positive reflection of higher incomes and the ability to live more independently than previously. For others, however – those who live in core housing need, who are socially isolated, or who have limited access to transportation, home care or community services – the scenario is not as positive. Having said this, the *overall* situation for housing is positive: seniors are more likely to be homeowners and to be mortgage-free than they were in previous decades. However, housing problems do persist for some seniors who live alone – renters, Aboriginal people and recent immigrants. Despite an average increase in seniors' incomes, the percentage of seniors with housing affordability problems decreased only slightly between 1996 and 2001.

As for personal safety, it appears that a significant majority of seniors feel secure in both their homes and neighbourhoods. This chapter also draws attention to the issue of institutional neglect and abuse of older adults.

While there has been an overall improvement in seniors' living conditions since the *2001 Report Card*, priorities for immediate action remain as important as they were at that time.

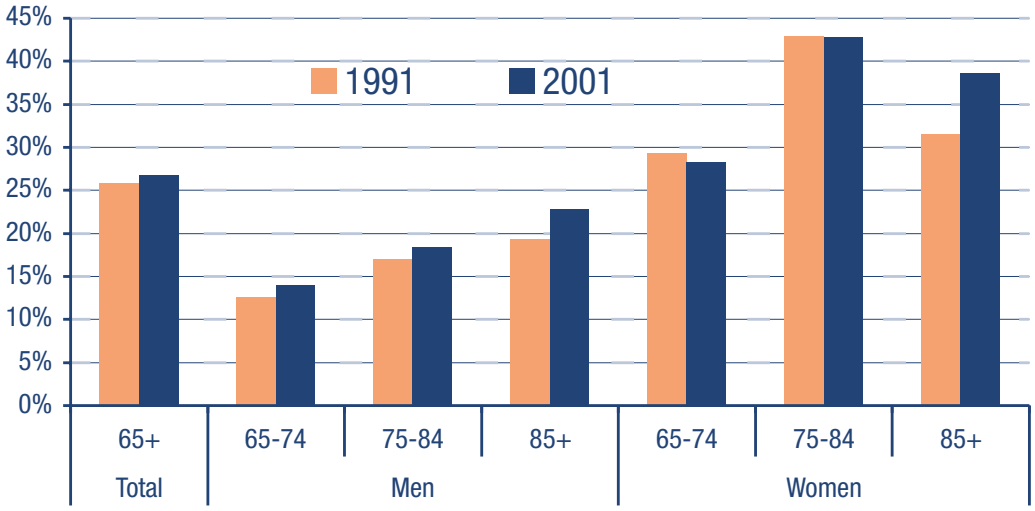
Summary table – Question 4

Topic	Indicators	Reference period	Trend direction	Grade
Living arrangement	Percentage of seniors living alone	1991 and 2001	Increasing, especially for 85+	—
Housing	Percentage of senior households homeowners	1996-2001 2000-03	Improving	B
	Percentage of senior homeowners without a mortgage	2000-03	Improving for older women	B
	Housing costs over the housing affordability threshold	1999; 1996 and 2001	Stable	C
	Senior households who are in core housing need	1996 and 2001	Improving	B
Transportation	Percentage of seniors with driving licenses	2000 and 2003	Improving for women	B
	Percentage of senior households with a vehicle	1999-2003 and 2000	Improving	B
	Access to public transportation	No data	—	—
Criminal victimization	Percentage of seniors by satisfaction with their personal safety and feeling of safety in diverse situations	1999 and 2004	Generally stable	B
	Percentage of senior victims of violent crime	1998, 2000 and 2003	Generally stable	B
	Seniors as victims of fraud	2005	—	—

Strengths

- A number of seniors are able to live alone due to good health, access to home care or community supports and/or financial independence. Over a 10-year period (1991-2001), the percentage of **seniors living alone** increased slightly from 26% to 27% (16% of men and 35% of women in 2001). This increase is more pronounced for those aged 85 and over. In 2001, 23% of men aged 85 and over and 39% of women aged 85 and older, lived alone (compared to 19% of men and 31% of women in 1991) (chart 4.1). Women aged 75 to 84 years represent the group of seniors most likely to live alone (43% in 2001).

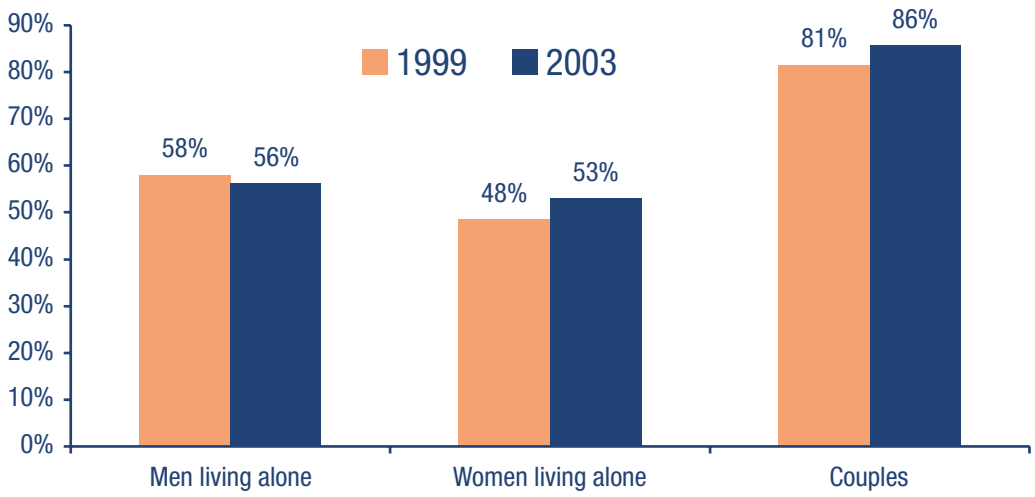
Chart 4.1 The proportion of seniors living alone increased in Canada between 1991 and 2001



Sources: Profile of Canadian families and households: Diversification continues. Living arrangements of seniors aged 65 and over by sex and age group, Canada, 2001.

- Between 1996 and 2001, the percentage of **homeownership** among all senior households increased slightly (from 69% to 71%). In 2001, 66% of non-senior households were homeowners. Between 1999 and 2003, the rate of homeownership increased for both senior couples and senior women living alone (chart 4.2).

Chart 4.2 Senior couples are more likely to be homeowners



Source: Spending Patterns in Canada,1999 to 2003 editions.

- In 2001, 83% of senior households who owned their home were **without a mortgage**, a proportion much higher than non-senior households (33%). Moreover, the rate of senior homeowners who were mortgage-free increased from 46% to 50% for older women living alone between 2000 and 2003.
- On average, seniors' **housing costs as a percentage of income** were below the affordability threshold (less than 30% of the total before-tax household income). In 1999, these costs represented 4% of the income of senior homeowners who were mortgage-free, 18% of the income of homeowners who still had a mortgage, and 29% of renters' income. Housing costs remain a problem for many renters.
- The level of **core housing need**[19] decreased slightly for senior households between 1996 and 2001 (from 18% to 17%). Two key trends explain this result: renter housing conditions improved, and more senior households became owners (owners are less likely to be in housing need).
- Access to **transportation** gives seniors greater independence, better access to services and improved opportunities for social interaction. In 2003, 67% of seniors had their **driver's license** (86% of men and 52% of women), a 2 percentage point increase from 2000. Between 2000 and 2003, the percentage of senior women having a driver's license increased by 2 percentage points.
- The percentage of senior households with a **vehicle** increased significantly between 1999 and 2003. The increase was highest for senior women living alone, from 41% to 50% and for couples, from 84% to 92%. In 2003, 72% of senior men living alone owned a vehicle (vs. 70% in 1999). This suggests that the new generation of seniors, especially women, are enjoying greater mobility than before.

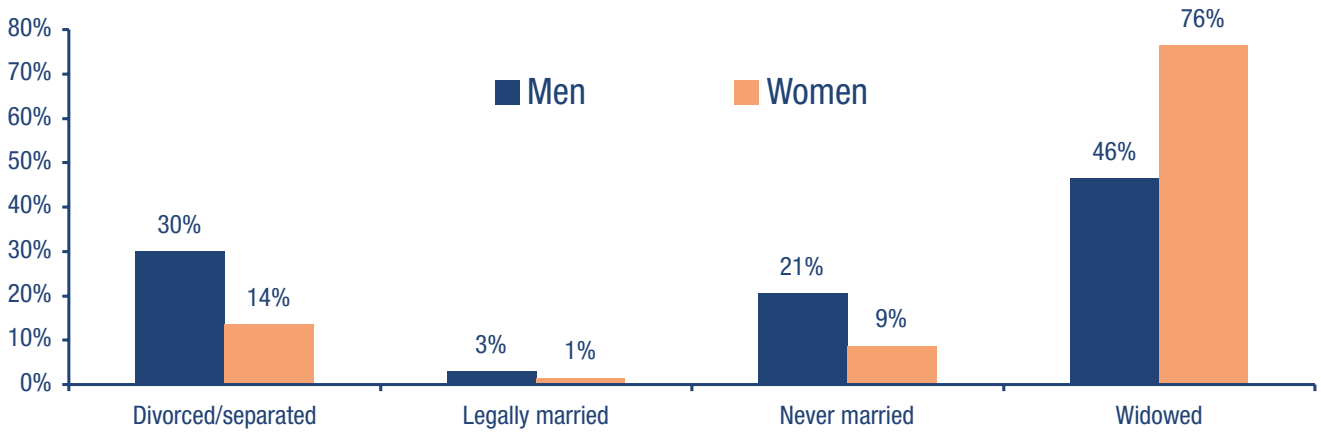
[19] Households are said to be in core housing need when out of necessity, they spend more than 30% of their before-tax income to obtain shelter that meets adequacy, suitability, and affordability standards.

- Most seniors feel they live in safe and secure environments. Ninety-five percent (95%) of seniors reported a high level of satisfaction with their **personal safety**. Most felt safe walking alone in their neighbourhood after dark and were not worried when home alone in the evening.[20]
- As reported in the *2001 Report Card*, seniors are still the least likely age group to become **victims of violent crimes.** Data from 2003 show that senior men were victimized at a rate of 184 per 100,000 and older women at a rate of 119 per 100,000. Overall, the trend in violent crimes against seniors decreased between 2000 and 2003 for both sexes.[21]

Weaknesses

- In 2001, more than one million seniors were **living alone** – almost three quarters of them were women. The 2001 Census data show that among seniors living alone, 69% are widowed and 18% are either divorced or separated; marital status of those living alone is very different for men and women (chart 4.3). Learning to live alone later in life following the loss of a spouse can be very challenging psychologically and financially (see "Senior women have lower incomes" box under Question 3).

Chart 4.3 Among seniors living alone, most women are widowed, while most men are either widowed and divorced or separated



Source: 2001 Census data analyzed by PHAC.

- A significant **percentage of seniors living alone** are at risk for housing affordability problems, health problems, and social isolation. In 2001, among seniors living alone, 40% of seniors were below LICOs, and 38% reported affordability problems. Seniors living alone are less likely to be happy compared to seniors living with a spouse or children; in part, because they spend more time alone and in part, because of low income.

[20] These statistics take into account only seniors who carry out these activities.
[21] This includes both family and non-family violent crimes. See also under "Weaknesses" for additional information on the specific trends.

- **Homeownership** is much lower (at 54%) for seniors living alone, especially women (chart 4.2). Moreover, only 31% of senior families living below the LICOs were homeowners in 1999.
- Not only are seniors who live alone less likely to own their home, they also are less likely to be **mortgage-free**. In 2003, about half of senior homeowners living alone had a mortgage while only one quarter of senior couples had a mortgage. For senior couples, the rate of senior homeowners who are mortgage-free decreased (from 79% to 76%) between 2000 and 2003.
- Despite an average increase in income of 20% for seniors between 1980 and 2000, housing affordability problems have generally remained stable. About 22% of seniors spent 30% or more of their before-tax income on shelter in 2001. Seniors' **affordability problems** are more prevalent among senior women and recent immigrants, and they increase with the size of the community they live in and with age, from 16% for those aged 65 to 74, to 27% for those aged 85 and older.
- Among senior-led households, affordable housing is a greater challenge for **renters** than for homeowners, as senior renters are four times more likely to report affordability problems (44% vs. 10% for senior homeowners in 2001).
- Not surprisingly, for seniors living below LICOs, shelter is a major expense. For those seniors, **housing costs** represented 44% of renters' income and 56% of homeowners' income (for those with a mortgage) in 1999. The housing situation of seniors on low income worsened over the last ten years, as housing affordability problems grew from 44% in 1991 to 52% in 2001.
- Senior households are more likely to fall below housing standards than non-senior households. **Core housing need affected** 17% of senior households in 2001 compared to 13% of non-senior households. Senior renters continue to have a relatively high level of core housing need: 36% compared to only 9% for owners in 2001.
- In 2001, 15% of seniors with **disabilities** were living in households in **core housing need**. In contrast, 11% of seniors without a disability were in core housing need. Core housing need is also higher for **Aboriginal seniors** and recent **senior immigrants**.[22]
- Seniors living in **rural and remote areas** face specific challenges in **housing**. With the shortage of appropriate housing for seniors, many seniors find it difficult to live independently. In addition, their homes may be too large or require too much maintenance for living alone during retirement. Downsizing is an issue when no smaller houses are available or when rental housing is often limited and unsuitable for seniors (e.g., stairs, no elevator, etc.).
- Some seniors do not have housing. While diverse factors are responsible for homelessness, **housing affordability** can be at play. The 2001 Census estimates that nearly 10% of shelter users across Canada were 65 years of age or over. Recent studies suggest that seniors tend to *avoid* homeless centres and hostels because of their poor conditions (noise, overcrowding, lack of toilet facilities and the threat of violence from younger shelter users).

[22] Up to 31% for senior-led Inuit households and 35% for those who immigrated between 1996 and 2001.

The current shelter system, which focuses on short term assistance, offers little help to older adults (who, for the most part, become homeless before the age of 50) in finding housing.

- A study on the care context of rural seniors reports that among those who did not drive, 21% said that **not having a driver's license** affected their ability to do shopping and 32% their ability to socialize.
- The Canadian Urban Transit Association estimates that seniors make up a significant portion (almost 10%) of the national public transit customer base and that the percentage can rise as high as 30% in smaller communities. Between 1996 and 2001, provincial governments reduced their annual investment in **public transit** by more than two-thirds. For seniors who use public transit this is an unfortunate development since it can seriously affect their mobility – especially in smaller communities.
- Senior women reported some fear about their **general safety**. In 2004, more than 55% of older women felt unsafe when using public transportation[23] at night; this constitutes an additional barrier to older women's mobility. Moreover, 20% of senior women were worried when home alone in the evening.
- While there was a decrease in **violent crimes** against seniors of both sexes between 2000 and 2003, violent crimes against senior men were higher in 2003 than in the late 1990s. Between 1998 and 2000, the rates of family violence and non-family violence against both senior men and women increased. Senior women are more likely to be victims of family violence, while senior men are more likely to be victims of non-family violence.
- Current research on **institutional abuse** is limited. After the age of 85, seniors are more likely to live in institutions and to suffer from Alzheimer Disease and other forms of dementia. Organizational policies, lack of staff training and low staff-resident ratios can compromise quality of care. Institutional abuse can take many forms: inappropriate or lack of staff-client interaction, low standards of nursing care, inadequate nutrition, overcrowded floors, lack of privacy, and issues of cleanliness. Senior women live longer, are more likely to reside in long-term care establishments, and are therefore at greater risk of institutional abuse.
- PhoneBusters statistics on **fraud** indicate that in 2005, 1,413 seniors reported being victims of phone fraud for an average amount of $3,358. In addition, 3,283 attempts to defraud seniors were reported.

Priorities for action

Priorities for improving seniors' living conditions include:

- Increasing affordable housing options
- Improving levels of accessible transportation for all seniors
- Improving standards of care for long-term care institutions

[23] Excludes senior women who do not use public transportation at night.

Data sources - Question 4*

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- **Seniors homeowners:** *Spending Patterns in Canada*, 1999 to 2003 editions, Statistics Canada. Cat. No. 62-202-XIE.

  Canada Mortgage and Housing Corporation (CMHC). *The housing conditions of Canada's seniors*, 2001 Census Housing Series: Issue 9 Revised, Research Highlight, Socio-economic Series 05-006, April 2005.

  Chawla, R.K. and T. Wannell. Housing costs of elderly families, *Perspectives on Labour and Income*, July 2004. Cat. No. 75-001-XIE. pp. 13-19.
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- **Housing affordability problems:** CMHC. *The housing conditions of Canada's seniors*, 2001 Census Housing Series: Issue 9 Revised, Research Highlight, Socio-economic Series 05-006, April 2005.

  Clark, W. What do seniors spend on housing? *Canadian Social Trends*, Autumn 2005. Cat. No. 11-008.

  Chawla, R.K. and T. Wannell. Housing costs of elderly families, *Perspectives on Labour and Income*, July 2004. Cat. No. 75-001-XIE. pp. 13-19.
- **Core housing need:** CMHC. *The housing conditions of Canada's seniors*, 2001 Census Housing Series: Issue 9 Revised, Research Highlight, Socio-economic Series 05-006, April 2005.
- **Homeless:** *Collective Dwellings*, Statistics Canada, 2002. Cat. No. 96F0030XIE2001004.
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- **Seniors with driving licenses:** *Canadian Motor Vehicle Traffic Collision Statistics*, 2000 to 2003 editions, Transport Canada, TP 3322 and CANSIM*, table 051-0001.

  Dobbs, B. et al. *Caring Contexts of Rural Seniors*, Phase II – Technical Report. Submitted to Veterans Affairs Canada, December 2004.
  http://www.hecol.ualberta.ca/RAPP/documents/Phase%202%20technical%20report%20FINAL.pdf

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* For more information on the surveys used, visit: http://www.statcan.ca/english/concepts/index.htm
* CANSIM is Statistics Canada's key socio-economic database accessible through the Internet. For more information, go to www.statcan.ca

- **Seniors with a vehicle:** *Spending Patterns in Canada*, 1999 to 2003 editions. Statistics Canada. Cat. No. 62-202-XIE.
- **Access to public transportation:** Information obtained by Canadian Urban Transit Association (CUTA).
- **Satisfaction with personal safety:** Gannon, M. *General Social Survey on Victimization, Cycle 18: An overview of Findings*. Statistics Canada, 2005. Cat. No. 85-565-XIE.
  http://www.statcan.ca/english/freepub/85-565-XIE/85-565-XIE2005001.pdf
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  http://www.statcan.ca/english/freepub/85-553-XIE/0019985-553-XIE.pdf
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Canadian Centre for Justice Statistics. *Family Violence in Canada: A Statistical Profile 2005.* Statistics Canada, 2005. Cat. No. 85-224-XIE.
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McCracken, M. et al. *Seniors in Rural and Remote Canada: Position Paper*. Advisory Committee on Rural Issues for the Canadian Rural Partnership, April 2005.
http://www.rural.gc.ca/acri/seniors_e.phtml

Question 5: How are seniors participating in society?

Overview

This chapter describes some of the major ways in which seniors participate in society. Through this participation, seniors make valuable contributions to society while also deriving benefits. To describe seniors' contributions to society, indicators measured their volunteer activities – both formal and informal – as well as their financial donations. Social engagement is an important measure of participation in Canadian life and an important factor influencing health and quality of life: seniors' social networks, their sense of belonging to their communities and their political engagement are all examined. Rates of employment and unemployment depict how many and what percentage of seniors are in the paid labour force and, in the case of unemployment, how many want to be employed but cannot find work. Unfortunately, mandatory retirement legislation continues to limit some seniors' ability to remain in the labour force. To complete the picture of seniors' participation in society, seniors' involvement in education and their use of technology are examined. Selected indicators measured formal learning activities and levels of Internet use.

About the information

- Information on informal volunteering, based on 1997 and 2003 data, could not be compared because it came from two different surveys in which the questions were asked in different ways.
- Results from the *Canada Survey of Giving, Volunteering and Participation, 2004*, were available for this Report Card. However, changes introduced in the Survey impeded comparisons with previous data. For this reason, the indicators (seniors' donations and seniors volunteering) were evaluated using comparable results from earlier surveys.
- The indicators for seniors' political engagement were somewhat difficult to assess as they measured less "traditional" forms of political activity (e.g., protest marches, petitions) and may not have accurately captured the true extent of seniors' political engagement.
- For some areas of seniors' participation, data were not available over different time periods, making it impossible to determine improving, worsening or stable trends. The grading for these areas is therefore more subjective.
- New data on social capital from the *2003 General Social Survey* and from the *2002 General Social Survey* on social support and aging have been important new contributions to the *2006 Report Card.*

- There were too few respondents aged 65 and older in the *2003 Adult Education and Training Survey* to conduct an analysis and publish data on seniors. Thus, there are no new data on formal learning activities.
- Seniors' employment rate was greater in 2005 (8% of seniors) than in 1998 (6%). It is very difficult from available data to discern whether this development is positive, negative or neutral for seniors. Whether the motivation for seniors to remain in or re-enter the labour force is one of financial necessity or a combination of factors (e.g., intrinsic value of work, greater fulfillment, enriching their retirement income, etc.) is unclear.
- It should be noted that this chapter assesses seniors' participation in society using information that is less precise, due to data limitations.

Report

GRADE: B

Seniors live longer and in better health than those of previous generations. Perhaps because of this, seniors are contributing to and participating in Canadian society in wider and more active ways. Seniors have a high rate of both formal and informal volunteering and accounted for a large portion of all charitable giving. Seniors are very socially engaged as indicated by their satisfactory social networks and their political engagement – the latter exemplified by their very high rate of voting in elections. Greater percentages of seniors – both men and women – were in the paid labour force in 2005 compared to 2001. Significantly fewer seniors than in 1994 reported in 2002 that mandatory retirement legislation prevented them from continuing to work. Finally, the number of seniors using the Internet is high and increasing, though still lower than other age groups.

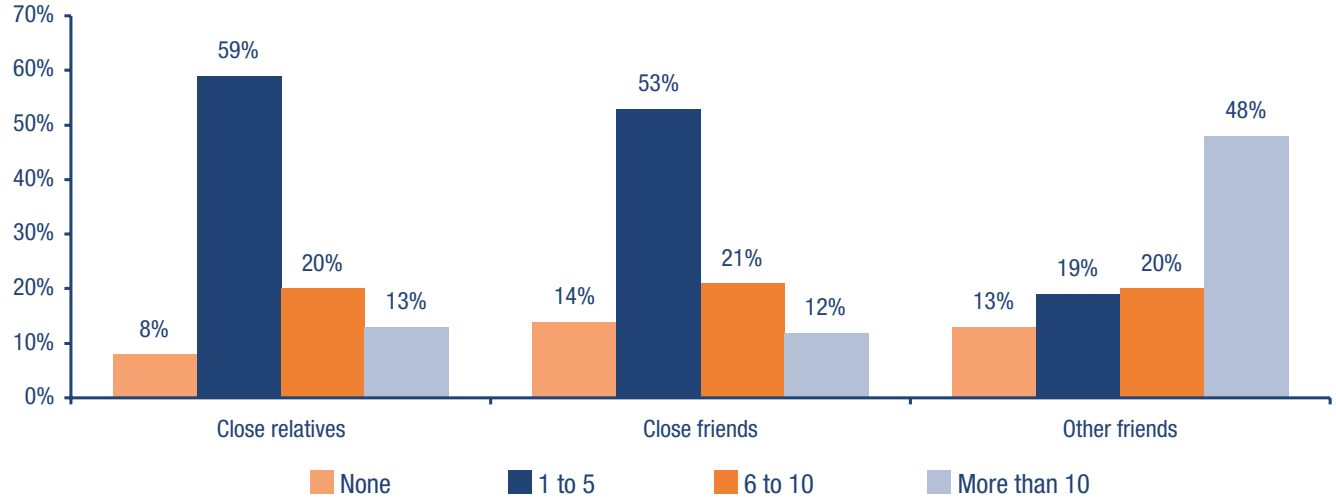
Summary table – Question 5

Topic	Indicators	Reference period	Trend direction	Grade
Contribution	Seniors volunteering informally	2003	Unknown	B
	Seniors volunteering formally	1997 and 2000	Mixed trends	B
	Seniors' donations	1997 and 2000	Worsening	C
Social engagement	Social networks	2003	Unknown	B
	Belonging to community	2000-01 and 2005	Improving	A
	Political engagement	2003	Unknown	B
Employment status	Working seniors	2001-05	Unknown	—
	Seniors looking for work	2001-05	Worsening	B
Age discrimination	Seniors affected by mandatory retirement policies	1994 and 2002	Improving	B
Education	Formal learning activities	No new data	Unknown	—
Seniors and technology	Internet use	1997-2003	Improving	B

Strengths

- In 2000, seniors accounted for 17% of all **formal volunteer** hours even though they represented only 12% of the Canadian population. On average, seniors volunteered 269 hours per capita in 2000, up from 202 in 1997.
- Most seniors enjoy a good **social network** as measured by the number of close relatives and close friends with whom they are at ease and can rely upon for help, and by the number of other friends they make (chart 5.1). While their networks are not as strong as those in younger population groups, seniors' social support does not drop off as much as might be expected given their age (death of family members and close friends, etc.).

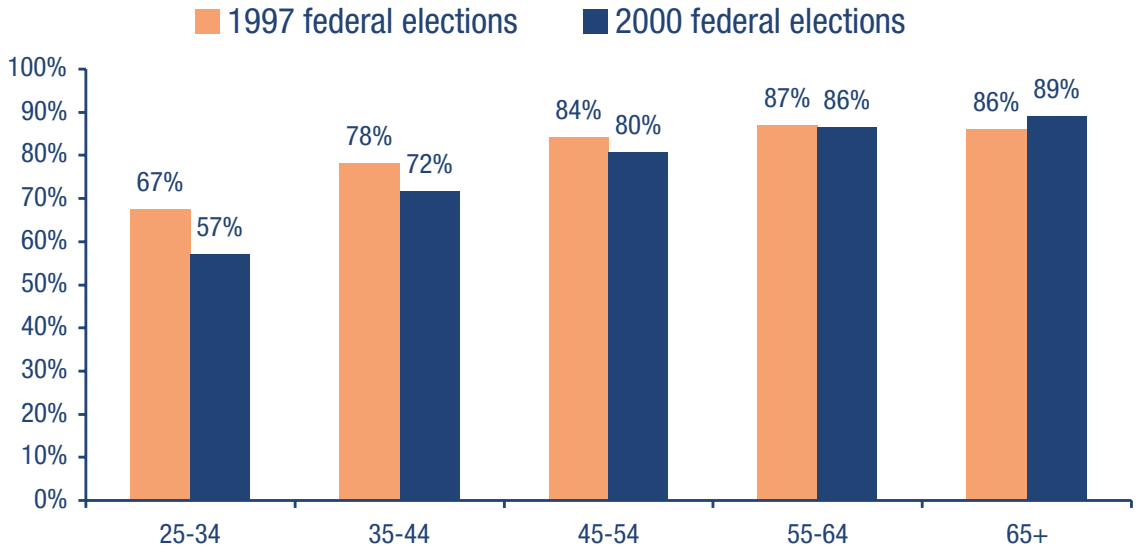
Chart 5.1 The number of family and friends in the social network of Canadian seniors, 2003



Source: 2003 General Social Survey on Social Engagement, Cycle 17: An Overview of Findings.

- Seniors are **politically engaged**. One in five seniors attended a public meeting in the past year. Compared to younger Canadians, seniors are more likely to follow news and current affairs: the percentage of seniors reporting that they follow news and current affairs daily increased from 85% in 2000 to 89% in 2003. Older Canadians are far more likely to vote than younger Canadians and to believe that voting is important. Almost 90% of seniors voted in the 2000 federal election (chart 5.2).

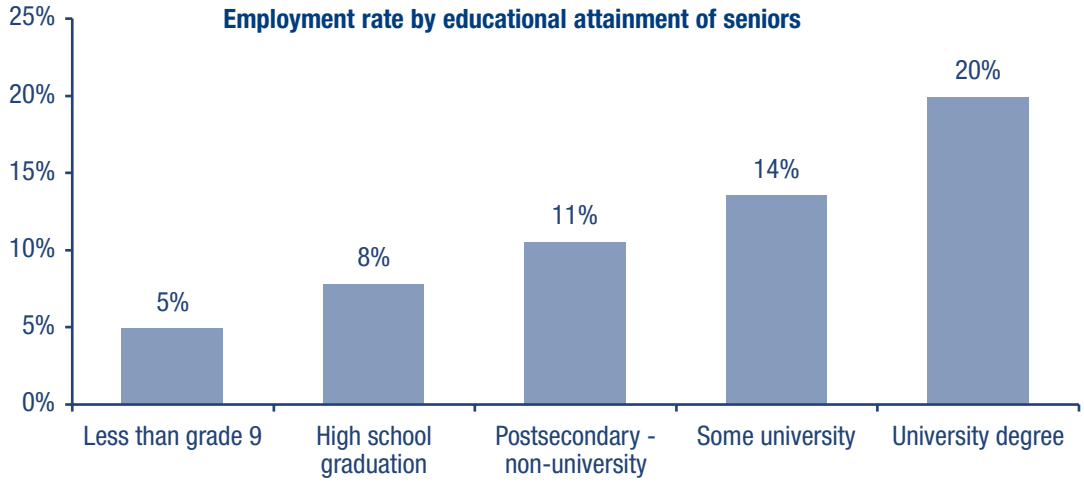
Chart 5.2 Vote in federal elections, by age group, 1997 and 2000



Source: GSS 2003 and 1997 National Survey on Giving, Volunteering and Participation, data analyzed by DAS.

- A higher percentage of seniors report a strong sense of **belonging to the community** in 2005 compared to 2001 (72% vs. 65%). Seniors feel more connected to their community than do other Canadians.
- The percentage of **working seniors** has increased (from 6% in 2001 to 8% in 2005). It is impossible to know, with present data, whether this increase is a positive, negative or neutral development for seniors. However, the following trends are positive. Census data indicate not only that more seniors are working after 65 years of age, but that they are older than the seniors who were working in previous years. Seniors aged 65 to 69 represented almost 60% of seniors at work in 2001. Working seniors are generally more educated (chart 5.3).

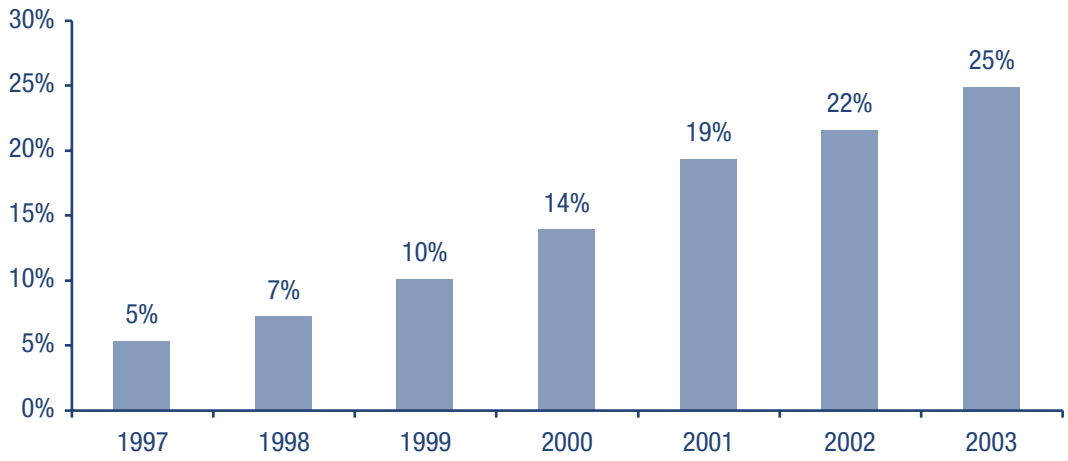
Chart 5.3 Working seniors were generally more educated in 2001



Source: Duschene, D. *More seniors at work.*

- Self-employment is more common among seniors than among younger workers (45% vs. 12% for workers aged 15 to 64 in 2001). Seniors are represented in most **occupations** and their job diversification increased between 1996 and 2001. Moreover, seniors are highly visible in some jobs (for example: farmers and farm managers, ministers of religion, judges, physicians, dentists or artists).
- In 2002, as compared with 1994, a smaller percentage of seniors indicated they were forced into retirement because of **mandatory retirement policies** (14.5% vs. 16.2%).
- Seniors are using **computers** and the Internet at high rates (chart 5.4). E-mail gives seniors an additional means to stay in touch with relatives and friends. Among those surveyed who used e-mail or the Internet over the previous month, 65% had communicated with relatives, and 60% had communicated with friends.

Chart 5.4 Internet use from any location – Households headed by a senior, 1997-2003 (%)



Source: Household Internet Use Survey, CANSIM table 358-0004.

Weaknesses

- While the average per capita number of hours that seniors **volunteer** increased from 1997 to 2000, the rate of seniors' volunteering actually decreased during this time period from 23% to only 18%. While this decrease in the rate of volunteering was true of *all* age groups, it is a negative development.
- Concerning seniors' **financial donations**, both the donor rate and the average annual donations decreased between 1997 and 2000. While the donor rate did not decrease significantly (from 80% to 77%), the average annual donation decreased from $328 to $308. Two other population groups (45-54 and 55-64) donated more than seniors in 2000.
- While seniors generally have good **social support networks**, compared to other Canadians, they are more likely to be socially isolated: 8% of seniors reported having no close relatives; 14% having no close friends; and 13% having no "other" friends (chart 5.1).
- Seniors are definitely **engaged politically** in terms of their voting patterns and their tendency to follow current affairs. However, seniors rank well below other age groups in their participation in other political activities: researching for political information; contacting a newspaper or politician; signing petitions; and boycotting products or participating in a march or demonstration. As mentioned in the "About the information" section, whether seniors' low level of participation in some of these other political activities represents a true weakness for seniors in being politically engaged or whether the indicators chosen skewed the analysis, is difficult to say.
- Recent analysis of the *2002 General Social Survey* was completed on **recent retirees** (those who first retired during the years 1992 to 2002 and were aged 50 or over at that time). Results show that one third of retirees from employment[24] were healthy and would have been willing to continue working under certain work arrangements. Among those who retired at age 65 or older, 25% retired involuntarily. These seniors were more likely to retire for health

[24] The other categories are self-employed and unpaid family workers.

problems, mandatory retirement policies or job disruptions, and were more likely to be worse off financially after retirement and to be dissatisfied with their life.

- More than 22% of recent retirees returned to **some paid work** after the first retirement. Among them, 38% mentioned financial concerns as the reason for returning to the labour force. Others indicated they returned to the labour force because they did not like retirement (22%), missed the rewards offered by work (19%), or felt they were needed or wanted to help out (14%).
- Seniors' **unemployment rate** increased from 2.6% in 2000 to 3.4% in 2005 (table 5.1).

Table 5.1 Unemployment increased for seniors

	Seniors' unemployment rate (%)		
	Total	Men	Women
2000	2.6	2.6	2.9
2005	3.4	3.2	3.8

Source: Table 282-0002, CANSIM, Labour Force Survey.

- In 2002, one senior in seven reported involuntary retirement due to **mandatory retirement** legislation. Mandatory retirement legislation is still in place in five provinces – British Columbia, New Brunswick, Nova Scotia, Saskatchewan, and Newfoundland and Labrador.
- Access to computers and **Internet use** remains lower for seniors, compared to other age groups.

Priorities for action

Priorities for ensuring a better participation of seniors in society include:

- Better understanding the situation of working seniors
- Creating greater incentives for seniors who want to work
- Providing more opportunities for formal volunteering
- Abolishing mandatory retirement at age 65 in provinces where it still exists

Data sources - Question 5*

- **Seniors volunteering informally:** GSS 2003 data analyzed by PHAC.
- **Seniors volunteering formally:** Saunders. S. *The Giving and Volunteering of Seniors*, Fact sheet no. 11, National Survey of Giving, Volunteering and Participation. 2001.
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  http://www.givingandvolunteering.ca/pdf/factsheets/2000_CA_Giving_and_volunteering_in_seniors.pdf
- **Social network:** *2003 General Social Survey on Social Engagement, cycle 17: an overview of findings*, Statistics Canada, 2004. Cat. No. 89-598-XIE.
  http://www.statcan.ca/cgi-bin/downpub/listpub.cgi?catno=89-598-XIE2003001

  GSS 2003 data analyzed by PHAC.
- **Belonging to community:** GSS 2003 and 2000 National Survey on Giving, Volunteering and Participation, data analyzed by PHAC.
- **Political engagement:** *2003 General Social Survey on Social Engagement, cycle 17: an overview of findings*, Statistics Canada, 2004. Cat. No. 89-598-XIE.
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  Morissette, R., Shellenberg, G. and C. Silver. Retaining older workers. *Perspectives on Labour and Income*, October 2004. Cat. No. 75-001-XIE.

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  Shellenberg, G., Turcotte, M. and B. Ram. Post-retirement employment. *Perspectives on Labour and Income*, September 2005. Cat. No. 75-001-XIE.
- **Seniors looking for work:** CANSIM*, table 282-0002, Labour Force Survey.

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* For more information on the surveys used, visit: http://www.statcan.ca/english/concepts/index.htm
* CANSIM is Statistics Canada's key socio-economic database accessible through the Internet. For more information, go to www.statcan.ca

- **Seniors affected by mandatory retirement policies:** GSS 1994 and 2002, data analyzed by PHAC.
- **Internet use:** CANSIM, table 358-0004 and GSS 2003, data analyzed by PHAC.

References - Question 5

Schellenberg, G., Turcotte, M. and B. Ram. What makes retirement enjoyable? *Canadian Social Trends*, No. 78, Autumn 2005. Cat. No 11-008. pp. 12-14.

Policy Research Initiative. *Encouraging Choice in Work and Retirement*. Project report, October 2005, PRI Project Population Aging and Life-Course Flexibility.

Overall evaluation

As was the case in 2001, the health and quality of life of Canadian seniors is quite satisfactory in 2006. **The overall grade for this *2006 Report Card* is B.**

Health Status Grade: B-

Life expectancy for seniors has increased and a higher percentage of seniors rate their health as good, very good or excellent than was the case in the *2001 Report Card*. Having said this, the health picture for seniors is one of contrasts. Since the last Report Card, the low levels of physical activity have seen no improvement and the prevalence of certain chronic diseases has increased. Better personal health and chronic disease prevention practices would reduce seniors' activity limitations and dependence. Suicide rates among older senior men (85 and older) continue to be a serious problem.

Health Care System Grade: C+

Lacking good data in 2001, NACA had been unable to evaluate how well the health care system was serving seniors in its first Report Card. Establishing a "baseline" evaluation from new indicators and available data in this area is an important improvement in the *2006 Report Card*. Seniors report that they are highly satisfied with the health care services they receive. Analysis of the health care system performance using indicators developed by NACA indicates that, while there is room for improvement, the health care system is serving the majority of seniors quite well, whether measured by access or quality of care. Insurance coverage among seniors, while too low in many areas, is improving. One glaring shortcoming of the health care system is the lack of geriatricians. Other areas needing improvement include the lengthy median wait times for seniors receiving specialized care and the high levels of out-of-pocket spending on health care. Future Report Cards must be able to rely on better indicators and data to better measure certain aspects of health care delivery including care in long-term care institutions, home care delivery and palliative and end-of-life care.

Economic Situation Grade: B

Seniors continue to fare well economically. Average and median incomes have improved since the last Report Card and the percentage of seniors who have low income or rely substantially on the Guaranteed Income Supplement (GIS) or Old Age Security (OAS) has decreased. Identified as a priority for action in 2001, the economic security of seniors living alone has improved between 2000 and 2004 – for both men and women. A major improvement of the *2006 Report Card* over the 2001 edition is the enhanced description of the GIS and how its rules impact on the financial situation of seniors. Continued action is necessary to ensure that all seniors

eligible for the GIS receive it, and that those who are late in renewing their applications are not too severely penalized. To improve low-income seniors' living standards, the GIS and OAS benefits need to be increased to equal or surpass the low-income cut-off.

Living Conditions Grade: B

The majority of seniors enjoy good living conditions. More than other population groups, seniors enjoy mortgage-free housing; the rate of mortgage-free ownership has, importantly, increased for senior women, compared to 2001. Further, fewer seniors live in core housing need than was reported in 2001. Seniors generally have good access to transportation and feel free from the threat of crime. Though there has been a slight decrease in the percentage of senior renters living in core housing need since the *2001 Report Card*, it remains important to increase funding for affordable housing units. Increasing public transit funding will improve seniors' access to transportation in both rural and urban areas.

Participation Grade: B

As was the case in 2001, it is evident from this Report Card that seniors are actively participating in their communities and making significant contributions to Canadian society. Some public policies inhibit seniors' full participation in society. For example, a priority for action in 2001 was the abolishment of mandatory retirement. Though this policy situation has improved – with fewer seniors indicating they were forced into early retirement due to mandatory retirement policies – this issue remains a concern. In addition to the abolishment of mandatory retirement at age 65 in provinces where it still exists, a priority for immediate action is to provide training and flexible work arrangements for seniors who wish to continue to work. Research needs to be undertaken to understand the factors contributing to seniors remaining in the workforce. A final area of concern is the decreasing rate of seniors' formal volunteering.

Overall Grade: B

The National Advisory Council on Aging will continue to monitor the health and quality of life of Canada's seniors over the years to come. Future Report Cards (along with Interim Report Cards), will report the positive aspects of life for seniors but, just as important, will also point out the areas that require improvement by identifying problem areas and formulating priorities for action. By so doing, NACA will continue to place the necessary pressure on policy and decision-makers, ensuring that the interests of Canada's seniors receive the attention they deserve, and sustaining the momentum for policy action to improve their health and well-being.

List of tables and charts

Tables

Charts

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Your turn to report

We would appreciate receiving your views and suggestions on the *2006 Report Card* on seniors. You can send us your comments in a number of ways:

You can return this page to:
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You can fax us the form at:
613-957-9938

You can send us your comments by e-mail at:
info@naca-ccnta.ca

1. To what extent did you read the Report Card?

___ I looked at it briefly
___ I looked at it generally and read some sections
___ I read the whole report

2. How would you rate the information contained in the Report Card?

___ Very useful
___ Useful
___ Not very useful
___ Not useful at all

3. How do you find the length of the Report?

___ Report is too short
___ The length is right
___ Report is too long

4. Do you find the information easy to read?

___ Very easy
___ Easy
___ Somewhat difficult
___ Difficult

5. Did the charts help you understand the statistics? Did you find them:

___ Very useful
___ Useful
___ Not very useful
___ Not useful at all

6. One objective of this document was to report on indicators to assess the status and the evolution of seniors' conditions in Canada. Was this objective reached?

___ Very well
___ Well
___ Partly
___ Not at all

7. How could we improve the Report Card?

_____

_____

_____

_____

Help us evaluate our readers:

Are you 65 or over?	Yes___	No___
Do you work or care for seniors?	Yes___	No___

Thank you

Our thanks for taking the time to answer our questionnaire. Your answers and comments will be very useful in preparing the next edition of the Report Card.