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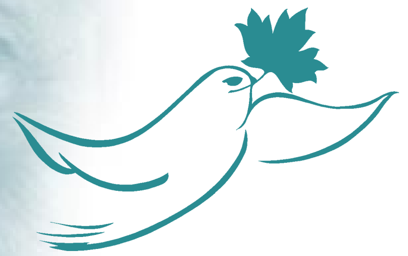

1999 and Beyond

Challenges of an Aging Canadian Society

Government of Canada Gouvernement du Canada

NATIONAL ADVISORY
COUNCIL ON AGING

1999 and Beyond

Challenges of an Aging Canadian Society

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WHAT IS THE NATIONAL ADVISORY COUNCIL ON AGING?

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

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

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Many seniors' organizations, gerontological associations and specialists were invited to read the first draft and provide their feedback by filling out a questionnaire. The Council is most grateful for their enthusiastic response to this consultation process and thanks them for their valuable input. Thanks are also extended to the members of NACA's Communications team.

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PREFACE

Since the National Advisory Council on Aging (NACA) was created in 1980, governments, researchers, the media and the public have developed a strong interest in determining and understanding the issues raised by an aging society. Some concerns have become more salient in the light of new information or recent social, economic and policy trends. However, much work remains to be done: too often, the issue of demographic aging and its impact is addressed from a narrow, sectoral, simplistic perspective. Yet the reality is complex. It is important to go beyond the confines of fiscal and budgetary analysis and identify the real issues involved in an aging society.

NACA decided to take stock of the situation of seniors today by addressing most aspects of life and trying to anticipate what the situation of future seniors will be in the short and medium term. NACA has attempted to outline the issues, challenges and opportunities facing public policy makers and all those interested in the issues raised by the aging population. In publishing this report, the Council also salutes the International Year of Older Persons.

The range of challenges and opportunities presented here is wide and varied. Some of the initiatives are aimed at particular sectors (federal or provincial/territorial governments, the private sector, community and voluntary organizations, researchers, individual Canadians), while others are more general or ambitious and require intersectoral action. The ultimate goal is to anticipate and take the necessary joint action. The Council hopes that the facts and the actions proposed in this report will at least guide decision makers along that path.

The implications of Canada's demographic change will be profound and enduring. It is up to everyone—individuals, governments, business, community organizations and seniors groups—to shape society in a way that maximizes the advantages of an older population and meets the challenges. Seniors want to play a full, active role in Canadian society, a society that must meet fairly the needs and aspirations of all age groups.

This report reflects many viewpoints besides those of Council members and we wish to thank all those who contributed to defining the issues and identifying the challenges.

Pat Raymaker
Chairperson

INTRODUCTION

TRENDS, CHALLENGES AND OPPORTUNITIES: AN OVERVIEW

Diversity within the same generations

Observation of the aging population in Canada shows that, for most seniors, this is a good place to grow older. Canadian seniors live longer in better health than in many other countries. A second observation is that seniors are becoming a more diverse group. For aging is an accumulation of experiences and circumstances: from birth, we undergo the cumulative and interactive effects of social, economic, environmental and behavioural factors. More seniors are living longer, more fulfilling lives than ever before with little change in physical and mental vigour. For others, the effects of disadvantages they have experienced during their lives can be seen in poverty, disease, disability and premature death. This shows that it is not the disparities between generations that characterize our society and should move us to action, but the inequalities that exist within every age group on the basis of social class, sex, occupation, etc.

For NACA, one of the major challenges of the next century will be to change the public image of aging to reflect this diversity and to modify policies and practices in all sectors of society to respond flexibly to the range of seniors' needs.

Age-based perceptions

Public perceptions of aging and seniors have created social barriers as well as entitlements. The image of seniors as poor, feeble and deserving of support which led to the establishment of age-based public and private pension programs and mandatory retirement is eroding, although it may simply be pushed onto the older senior years rather than eliminated. The vitality and prosperity of a growing number of seniors, combined with a difficult social and economic climate, have fuelled the opposite depiction of seniors as wealthy, capable and less deserving of support. A negative outcome of this tension is the tendency to lose sight of the needs of "vulnerable seniors" and to forget that a similar proportion of Canadian seniors as children live in poverty.

The positive side to the contradictions in the public image of seniors includes the heightened interest in understanding seniors' paid and unpaid contributions to society, a stronger questioning of mandatory retirement practices and a more thoughtful approach to entitlements that considers needs and capacities rather than age alone. These views are likely to change as people come into direct contact more often with seniors in a variety of roles, and as older people who are public figures belie the stereotypes.

Adjusting to demographic aging

In 1998, about 3.7 million Canadians, or 12.3% of the population, were 65 years of age or over. This represents an increase of one million seniors in the population over the past decade. However, the dramatic growth in the number and proportion of seniors lies just ahead, in the first four decades beyond 1999. By the time baby boomers begin to turn 65 in 2016, there will be 6 million seniors, or 16% of the population. By 2020, there will be as many seniors in the population as children (19%). By 2041, their numbers will have grown to 10 million, comprising 22.6% of Canada's population.

This aging of the population is not a transient demographic phenomenon that will quickly fade away when the "baby boom" generation is gone. The persistently low fertility rate will maintain a high ratio between the number of seniors and the rest of the population for the foreseeable future. The fact that people are living longer will only accentuate the aging of society, and even very high immigration rates will not have a very great impact in the medium and long term.

One approach to aging would be to take measures to lower the age of the population, while another would be to help society adapt to aging. This paper advocates the second approach, and does not enter into the debate about whether the population structure should be modified by adopting high fertility or immigration policies that would limit or correct the current trend toward an aging society. However, any barriers preventing individuals from deciding freely whether or not to have children should be eliminated. While certain measures have been taken in that direction, the fact remains that social and labour policies could provide more support for those who choose to have children.

For now, the indications are that the transition toward a society in which seniors will represent a quarter of the total population is part of the natural development of Western countries. The aging society of today will become the aged society of tomorrow, and the repercussions of this demographic change will be profound and ongoing. The effects of the demographic changes will be slow and spread over several decades, and the economic pressures governments might experience will not produce a crisis. It is up to individuals, business and governments to begin changing their practices now to maximize the advantages of the demographic changes taking place and minimize the disadvantages. To do this, it is essential to predict the consequences of the aging baby boom generation that will be different from the seniors of today in many respects and to plan accordingly.

Tomorrow's seniors will be different from today's

Many studies have pointed out the unprecedented nature of the current aging process: *people are not aging now the way they used to.* The reality of being a senior has changed, and seniors today bear little resemblance to their counterparts before the Second World War or in the last century: they not only are living longer, but also are in better physical and mental condition and their economic situation has much improved. From this perspective, making chronological age an indicator of dependency, or regarding people 65 years of age and over as a burden on government no longer reflects the reality of aging today.

The new generations of seniors will also have little in common with preceding generations. It is reasonable to believe that, with their higher education level, seniors will have a better knowledge of programs and services, that they will be more open to health promotion messages, more inclined to participate in educational, political and voluntary activities, and more likely to demand their rights. They will be accustomed to keeping their work skills up-to-date, and will find it easier to remain in the labour market if they wish to and make suitable preparations for retirement.

With this awareness of the changing realities of aging, there is now talk of the "third age" and "fourth age." Following youth and adult life dedicated to work and family comes the "third age," a time of life in which retired persons, most of whom are healthy and independent, are free to do what interests them and carry out projects that they have long been putting off, for lack of time. It is the last stage of life, the "fourth age," that is now associated with illness, dependency and, eventually, death.

This suggests that the direction of social policy must be changed to enable seniors who are in good physical and mental health to lead an active life and play roles that enable them to continue to develop and achieve personal and social goals. There are also practical and ethical issues, such as the extent to which the impact of marginalization based on age will simply be shifted from the beginning to the end of the active retirement period, delaying by a few years the application of stereotypes that are still negative to those who are the oldest members of our society and the most vulnerable—that is, those who are in the "fourth age."

A comprehensive study of the issues

With increasing life expectancy and more older adults in retirement, come accusations that seniors are taking more than their fair share of scarce societal resources which should instead be allocated to other population groups (e.g. poor children and their families). Moreover, there are justifiable questions about whether the policies of intergenerational cohesion will be sustainable, given the growing imbalance between the size of the group receiving benefits and the size of the group paying the costs. These questions apply particularly to pensions and health care.

Demographic aging impact studies sometimes do not take into account certain research results or lines of thought. Some examples are:

- Intergenerational solidarity is a strong value with seniors: many invest time and money for their families. Many also join voluntary organizations. These kinds of social commitment are unfortunately underemphasized, undervalued and underreflected in the development of public policy.
- Government plays a key role in ensuring the viability of community activities and public support which promotes family solidarity. The government trend toward withdrawal could represent a setback to family and community support and partially or totally cancel out the expected savings.
- Contrary to popular opinion, demographic aging is not the most important factor in determining future public sector costs and revenues. While health care and social security costs will increase with changing demographics, other costs will decrease (e.g. education costs). The total expenditure for all budgetary categories combined would increase at very much the same rate as the total population. The main problem, therefore, is how to effect shifts within budgets to accommodate rising demands in some areas coupled with falling demands in others.
- Society has so far taken few steps to use the potential of its older members. Business and government practices for managing the aging

work force are usually limited to providing early retirement packages to older workers. Seniors who wish to remain active in the work force are prevented from doing so by, for example, mandatory retirement policies based on an arbitrary age limit rather than an evaluation of their skills and ability to contribute to society.

- Seniors do more than just receive; they also contribute to the public purse through personal income tax, consumer taxes, participation in business and industrial concerns that pay corporate income tax and, to a lesser extent, their participation in the labour market.

According to NACA, the challenge for public policy makers is to develop an overview of the general social and economic situation and anticipate the effects of their actions on every aspect of human activity.

Public support reinforces private support

Many seniors become involved in community activities and these have an effect on their autonomy and quality of life. Such activities have a major, positive impact on individual well-being and indirectly contribute to reducing health and social services costs. The funding of community programs plays a determining role in promoting individual commitment and partnership formation, and in preventing seniors' social isolation. Society as a whole, including government and the private sector, receives many benefits and services by guaranteeing the sustainability of community projects that meet ongoing community needs. Unfortunately, the government withdrawal that has been taking place for several years is endangering the gains of the past. For example, since the abandonment of the New Horizons program, which funded 39 000 projects from 1972 to 1995, governments and communities have not been able to support seniors' community programs as they did in the past. There is a pressing need to adopt another strategy to support this type of senior empowerment and encourage their social involvement.

Government also plays a crucial role in maintaining and strengthening exchanges between generations. For example, when society assumes collective responsibility for providing part of the care of its seniors, through health care, extended care or pension benefits, the children and families of seniors are relieved of a burden that would be too heavy for them to bear alone. A number of studies have shown that, contrary to popular belief, public support does not lead people to be less committed to their families; rather, it encourages intergenerational family support. We understand a little better today the interdependence of these two types of intergenerational exchanges: for families in which the children and parents have limited resources, withdrawal of public assistance creates an accumulation of burdens and problems that can lead to a breakdown of private support.

Promoting the maintenance of social commitment

Increased life expectancy, improved health and earlier retirement will require individuals and society to develop a focus other than paid work and give the third age a true social function. There is a shared responsibility here: society should offer its seniors the opportunity to play a true social role, and older adults need to ask themselves how they can maintain their level of social commitment.

Age-linked expectations and opportunities will evolve as demography changes. The need for a fuller participation by Canadians of all ages in paid and unpaid activity to maintain economic prosperity and social well-being may temper early retirement expectations among some baby boomers, yet hold the prospect of continued earning power among others for whom retirement creates financial hardship. The need to maintain an adequate, well-trained, motivated and productive labour force may finally lead to concerted societal efforts to break down the rigid distinctions among the time for learning, for care, for work and for retirement, allowing greater flexibility of movement between life stages for all adults. Attitudes and practices which do not recognize seniors' contributions, or which make it difficult for older adults to make a contribution to society, diminish their dignity and undermine individual and societal prosperity.

Filling the knowledge gap

There is a sound gerontological knowledge base and research capacity to begin preparing an aging policy. However, significant public investment in further research and data collection is required to fill knowledge gaps in many critical areas, and more energy needs to go into knowledge transfer.

For example, we need to develop a better understanding of the linkages between health and the environmental, social and economic conditions. Models of effective intervention to improve health outcomes throughout the life cycle need to be developed and tested. Transitions from health to disability and death should be tracked to determine patterns of vulnerability and the appropriate type and timing of support. Information on lifetime patterns of earning, saving and spending should be collected, as well as information about the effectiveness of various incentives to influence individual behaviour (e.g. choices related to work, education and family, savings, retirement planning).

The need for an intersectoral approach to policy development

In 1991, NACA recommended a national intersectoral aging policy that involved all levels of government. This approach is gaining momentum both federally and provincially/territorially, as it becomes more widely accepted that the health of all Canadians can be improved and inequalities reduced only by addressing the economic, social and environmental conditions that determine health.

Within the health care system itself, perspectives are broadening to consider the interface between health services and other services that add value to health care, such as housing and social support.

The connections between education, occupational history, family history and pensions also compel inclusive policy approaches involving not only governments, but also employers, unions and community groups. A significant step in the direction of an intersectoral approach is the adoption by federal, provincial and territorial Ministers responsible for seniors of a National Framework on Aging for guiding aging/seniors policy and program development.

Players' roles in connection with the challenges

This report attempts to delineate the responsibilities of the individuals, the family, the community (voluntary and private sectors) and the State with regard to the challenges to be met. Certainly, the individual partners' ability to play their roles greatly depends on the support they receive from the other partners. Some actions involve specific players and sectors, but others, which are more general and ambitious, necessitate intersectoral action.

The federal, provincial, territorial and municipal governments are responsible for putting in place the frameworks needed to promote well-being and independence and to facilitate action by individuals, families and community stakeholders. In this context, governments are, for example, responsible for maintaining a public pension plan, which remains the only guarantee of a minimum level of financial well-being for many of today's and tomorrow's seniors, and for reinforcing and encouraging private solidarities and social commitment on the part of individuals by offering support to informal caregivers and by financially assisting community organizations. Municipalities should include in their urban development plans and municipal bylaws the conditions required to meet the specific needs of an aging population: keeping sidewalks clear of snow, having sufficiently long lights at pedestrian crossings, having a variety of housing types for seniors, and so on.

Health system administrators are called upon in many ways—for example, adapting services and information to reflect the specific needs of seniors belonging to ethnocultural groups, or creating integrated community home care programs that recognize and support the services provided by volunteer informal caregivers and by health professionals. The staff and administrators of extended care institutions should provide a living environment that is managed primarily on the basis of the residents' needs, should work to maintain the residents' abilities, should provide rehabilitation, and should encourage cooperation on the part of the residents and the members of their families.

Directly and indirectly, the business community and industry also play an important role, both as entrepreneurs and as corporate citizens. The private sector will have to adjust to the aging of its clientele and provide services and products that reflect the needs of seniors. Real estate developers and architects must ensure that the houses and apartments being built are universal in design—that is, that they are suitable for persons of all ages. The pharmaceutical industry must more precisely assess the effect and efficacy of drugs when consumed by seniors. Manufacturers will have to adapt not only their products, but also their packaging and labels. With regard to the workplace, the private sector is invited to adopt labour policies that are flexible enough to recognize their employees' family responsibilities toward their children and elderly parents—that is, to adopt family-friendly policies. The private sector is responsible for providing training and educational activities for all workers, so that they may retain and improve their skills and motivation and achieve success in their working life and in retirement. This is eminently compatible with our economic productivity, and the private sector will benefit greatly from this approach.

Since health, adequate income and integration into a social network are important factors in ensuring a minimum of well-being in retirement, individuals must, to the extent they are able to do so, stay physically and mentally fit, manage and conduct their own affairs, and take the steps necessary to remain socially involved. In as much as this report is directed at individuals, NACA wishes to encourage everyone, in particular men, to make good use of the health system to prevent and detect disease earlier, and to promote a culture in which the tasks and personal cost of raising children are shared more equitably by men and women. However, this does not mean that an individual faced with illness, financial problems, social isolation or inadequate sources of information is to be blamed. An individual can assume his or her responsibilities only when the opportunity to do so exists and he or she is in a position to make choices.

These are only a few of the challenges facing various players in society. The following chapters list many more issues and challenges and present a selection of indicators that will make it possible to measure the development of Canadian society with respect to the senior population. We hope that policy makers will find this document a useful guide for their strategic planning and that it will lead to concrete actions that will support the independence and well-being of Canadian seniors. With good leadership and engagement of all sectors, Canada will continue to evolve as a caring society for all ages.

1. DIVERSITY OF SENIORS

1.1 WOMEN AND MEN

Issues

In 1996, women accounted for 58% of the seniors' population, and 70% of the 85 and over category. Senior women have a higher life expectancy than men: a woman who is 65 years of age can expect to live an average of four years longer than a man of the same age. Two of these years of life are characterized by severe disability and only one is free from disability.

Senior women are more likely than senior men to have certain chronic health conditions, such as osteoporosis and incontinence. Prescription and non-prescription drug use (particularly drugs for managing pain, sleep and anxiety problems) is higher among senior women than men, and the risk of adverse drug reactions is consequently also greater among women.

Cardiovascular disease is the leading cause of death for both sexes and is more likely to go undiagnosed and untreated in women. However, heart disease accounts for 50% more deaths in senior men than senior women (1994 data). Cancer is also a major concern. Since the 1980s, the overall death rate from cancer has grown more slowly in senior men than senior women. In 1996, the estimated number of new cases of lung cancer diagnosed in women aged 70 to 79 was nearly triple the 1980 rate. However, the mortality rate from lung cancer in men was 68% higher than in women (1994 data). The incidence of prostate cancer, always higher than the incidence of other cancers in senior men, has been steadily increasing since the early 1980s, in part because of early detection, which helps improve treatment. New cases of breast cancer and breast cancer deaths have also increased among senior women since the 1980s.

Senior men tend to have a higher-risk lifestyle than women: they are more likely to smoke or drink regularly or in larger amounts than senior women. Research also suggests that men's tendency to express themselves in a more aggressive manner has a ripple effect on their mental health: men tend to adopt more risky and self-destructive behaviours when faced with emotional turmoil, whereas women tend to become more depressed. The suicide rate in senior men is four times higher than in women, although the incidence of suicide in seniors has been dropping since the early 1980s. The risk factors for suicide include a decline in physical health, mental health problems (e.g. depression, dementia), bereavement and loneliness. But men are also much more reluctant to get medical attention, less likely to go for regular check-ups and they tend to wait until a problem is advanced before seeking help. Often, they will do so only under pressure from their wife or daughter. Understanding the historical and cultural factors of such reluctance would help to develop innovative approaches to overcome this barrier to better health.

Because labour force participation has an impact on the financial situation of people in their senior years, senior men are more financially secure

than women. In 1995, 1% of senior men reported that they had never held paid employment, compared to 21% of senior women. As senior men are more likely to have held paid employment, 25% of their incomes (in 1994) came from pension plans from a private sector job, compared to 12% for women. Senior men are less likely to have low incomes than senior women (11% and 26% respectively), and the average income of married men was nearly double that of married senior women in 1994.

Major life-course events in the lives of women, such as the decision to pursue higher education, to marry, to bear children, and to obtain paid employment outside the home, are influenced by societal expectations of women and their "appropriate" role in society. These events and decisions have significant consequences for the health and well-being of women in their later years. A major determinant of a woman's earning potential is whether she has children. While both parents make investments in the well-being of their children, it is, in the majority of cases, the mother who reduces her hours of paid work and opportunities for advancement in order to absorb the unpaid work that raising children involves. It is motherhood that continues to cost women in their senior years. For example, on average, the income of women aged 65 and over is 63% of men's. The choices and opportunities available to young and middle-aged women today are far greater than those of their mothers and grandmothers. However, the presence of children, added to the persistent undervaluing of many traditionally female-dominated occupations, may continue to disadvantage today's young and middle-aged women in their senior years.

The higher life expectancy of women and the traditional age gap between husband and wife increase the likelihood that they will be widowed. The absence of a spouse to take care of them in their old age is one of the reasons why a larger percentage of women live in institutions than men. Senior men are at much lower risk of being widowed than senior women, and are three times more likely to remarry following the death of their spouse. Because they are more likely to predecease their spouse, they have greater access to social support and informal care during illness, and are therefore far less likely to be institutionalized than senior women.

Finally, sexual orientation can have an impact on relations with family members, friends and social services, thus directly affecting the quality of life of homosexual seniors. The social stigma still attached to homosexuality, which means that many lesbians and gays grow old outside the social mainstream, limits their access, when in need, to the formal and informal care networks. For example, the absence of close ties with family or of children limits the support available in case of illness and increases the likelihood of institutionalization. Financial problems can also arise when homosexual couples are not recognized by governments and other institutions.

Challenges

- Encourage greater workplace flexibility and support for employees (men and women) with caregiving (child and elder care) responsibilities (family-friendly policies).
- Promote a culture where the personal cost of raising children is shared more equitably among men and women.

- Develop targeted physical and mental health promotion (e.g. smoking cessation, improvements to diet, exercise, reduction in alcohol use) prior to and during the senior years to prevent subsequent health conditions and disease.
- Encourage men to use the health care system as a way of promoting health and preventing and detecting illness (e.g. regular visits to the family doctor and promptly visiting a health care professional when a health problem arises).
- Ensure that the work that women do is valued and compensated adequately.
- Encourage employer-sponsored pension plans for non-standard work.
- Ensure through the use of "gender-based analysis" that government policies in areas such as tax, pensions and health care redress, rather than worsen, inequalities between the sexes.
- Ensure the provision of adequate community-based support for senior women and men living alone to prevent or delay institutionalization.
- Ensure adequate income security for older women, particularly those who depend entirely on public pension incomes.
- Encourage physicians and researchers to address the problem of cardiac illness in women, as many go undiagnosed.

Indicators of change

- Increase in the number of workplaces, both public and private sector, that have flexible, family-friendly policies which recognize women's and men's responsibilities toward their families, that do not penalize women for their dual roles, and provide women with equal pay for work of equal value.
- Decreased percentage of unattached senior women with incomes below the Low Income Cut Off (LICO).
- Increased percentage of men making appropriate and timely use of the health care system.
- Increased health expectancy for men and women.

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1.2 SENIORS FROM ETHNOCULTURAL GROUPS

Issues

Immigrants represent 26% of seniors living in Canada and roughly the same proportion of persons aged 45 to 64. Most of the immigrants currently aged 65 and over arrived quite a long time ago: according to 1996 figures, 61% of them arrived before 1961. Almost all the seniors now arriving in Canada fall within the category of family reunification, and they account for a small percentage of the immigrants arriving each year (4% of total immigration in 1995).

Some ethnic groups have a long history in Canada and have well-established communities. Others are relatively recent arrivals. Approximately 4.5% of all seniors speak neither English nor French, compared to 1.7% of the population aged 15 to 64. Communication difficulties can lead to inappropriate health care, such as deficient treatment, unnecessary testing and premature discharge. Interpretation services, both linguistic and cultural, are often required to ensure effective care.

Seniors from various ethnic groups can have different customs and preferences from the main culture in terms of lifestyle, forms of family interaction, senior networks and support networks. Consequently, they adopt different strategies for dealing with aging. Canadian cultural diversity means that the specific needs of the ethnocultural groups making up the Canadian mosaic must be identified and understood.

Cultural and linguistic differences, as well as structural barriers such as racism, can hamper access to educational and employment opportunities throughout all life stages, and to services and information in the senior years. However, the amount of time that has passed since immigration and age at landing affect the poverty rate, knowledge of institutions and adjustment to Canadian society. For example, some studies have shown that after 10 to 20 years, immigrants reach a level of prosperity comparable to the general population. Eligibility for Quebec or federal pension plans and the level of benefits depend on the number of years of labour force activity in Canada. Finally, senior immigrants are entitled to the full Old Age Security Pension and Guaranteed Income Supplement only after living in Canada for 10 years.

Seniors from ethnocultural groups may be more vulnerable to mental health problems. Factors which may contribute to greater loneliness or depression include uprootedness from the culture of origin, poor understanding of the dominant culture, and lack of meaningful contact with persons outside the family.

Challenges

- Ensure immigrant seniors' access to second language education and acculturation to life in Canada and evaluate successful outreach mechanisms.

- Increase the number of health and social service professionals and volunteers who come from ethnic/racial minority communities and are trained in the culturally appropriate provision of care for seniors from a variety of backgrounds.
- Ensure that people who immigrate to Canada as seniors have access to adequate economic support.
- Increase opportunities for social participation for immigrant seniors outside the immediate family, both within their cultural community and within the mainstream community.
- Adapt services and information to incorporate the specific needs of seniors from ethnocultural groups to ensure accessibility. Services need to be culturally sensitive, which includes the utilization of languages other than English and French and pictograms for seniors with low literacy levels.

Indicators of change

- Increased percentage of ethnic seniors who can communicate effectively in either official language.
- Increased availability of culturally sensitive health care and social services.

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1.3 ABORIGINAL PEOPLES

Issues

Over the past three decades, the health of Aboriginal peoples has improved in many respects. For example, the mortality rate has dropped as a result of improved living conditions and improved access to health care services. Life expectancy at birth has significantly improved, owing in large part to the rapid decline in infant mortality. But despite these recent improvements, the health situation of Aboriginal people is not equal to that of the rest of the Canadian population. They are still faced with a disproportionate number of serious health problems, and many develop chronic illnesses and disabilities earlier in their lives than the rest of the Canadian population. Degenerative diseases such as tuberculosis and diabetes are four times more prevalent in Aboriginal people than in the rest of the Canadian population, and the rate of disability is twice as high. Furthermore, a high percentage of Aboriginal people live in remote areas in rough climates, where the cost of living is higher and the limited means of transportation impede access to timely emergency medical care.

The Aboriginal population is not homogeneous. There are, for example, major differences between Aboriginal people in the North and the South, and between those living on reserve and off reserve. Health indicators and accessibility of health services vary widely depending on whether an individual lives on or off reserve. The life expectancy of First Nations members living on reserves is nine years less than other Canadians, but the gap falls by half among Status Indians living off reserve. The health reforms designed to shorten hospital stays have had a major impact on reserves, where community support services are virtually non-existent. The lack of resources often means that Aboriginal seniors must leave the reserves to be hospitalized or placed in long-term care facilities, finding themselves in culturally unfamiliar, distant environments. This increases the costs to the system and produces social isolation for individuals.

The majority of Aboriginal seniors today have spent part of their lives in difficult conditions (e.g. poor diet, inadequate housing, alcohol and tobacco use, low self-esteem, etc.). They have been marginalized outside their communities, and even within their communities their economic, spiritual and other kinds of contributions may be viewed as less and less important. Housing both on and off reserve remains a major problem; much of it is in deplorable condition, housing discrimination exists (off reserve) and Aboriginal seniors move frequently. Aboriginal seniors need the same services as all Canadian seniors, as well as services appropriate to their unique cultural situation that require a particular approach.

The Aboriginal population is younger than the Canadian population, and will continue to be for some time yet. However, the decline in mortality and morbidity rates over the past half century suggests that there will be a steady increase in the number of Aboriginal seniors over the coming decades, despite their abnormally high health risks. Taking 55 as the start of old age for Aboriginal

people (because they are more disadvantaged in health terms than other Canadians), the number of Aboriginal seniors among the First Nations and Inuit could triple from 60 000 in 1998 to 180 000 in 2021. There could be a resulting increase in demand for health care services, especially on reserves, where such services are scarce.

Talks on self-government for Aboriginal peoples can open up new perspectives for the future. The transfer of administrative powers can create institutions that respond to the social and cultural diversity of Aboriginal peoples by making use of their self-knowledge and creativity. The political dimension will be one of the determinants of the future well-being of these populations.

Challenges

- Reinforce efforts to improve the health of the Aboriginal population by working closely with Aboriginal communities on health determinants.
- Develop culturally appropriate health care and promotion programs aimed at problems that particularly affect Aboriginal people.
- Improve the availability of and access to home care and community services on reserves.
- Ensure that the quality and accessibility of ongoing health care services provided on reserves are comparable to provincial/territorial standards.
- Develop policies and programs that reflect the cultural and linguistic reality of Aboriginal seniors, both on reserves and when they are forced to leave their communities to obtain services far away.
- Educate health care and social service providers about Aboriginal cultures and recruit and train more Aboriginal professionals.

Indicators of change

- Greater comparability between Aboriginal and non-Aboriginal people in health and socio-economic status and living conditions.
- Increased availability and access to on-reserve community and home care services.

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1.4 SENIORS IN URBAN, RURAL AND REMOTE COMMUNITIES

Issues

While the majority of Canadian seniors live in urban areas (urban areas are defined as having a minimum population concentration of 1000 and a population density of at least 400 per square kilometre), about 20% of seniors live in rural and remote areas (all territory outside urban areas is considered as rural and remote areas). The nature of rural communities in Canada is varied, with great regional differences. Nevertheless, some generalizations are possible. Benefits of living in a rural area can include less expensive housing and taxes, fresh air and a more peaceful way of life. Many have migrated to those areas for their retirement to enjoy such benefits. But these benefits are often offset by more expensive food and transportation costs.

For many rural seniors, limited access to services and amenities—including housing options, public transportation, professional and commercial services, home care, and specialized health and social services—may create significant barriers to independence. These same barriers apply to seniors living in remote communities and to many Aboriginal communities. For example, in 1993, there were only half as many physicians per 1000 population in rural Canada as compared to larger urban centres. With decreasing functional abilities, one may choose to move to larger centres where more services are available. However, money can become a central issue if someone has to move from a region where housing prices are modest to a larger centre with higher-priced housing markets.

Some communities have difficulty financing the services required by their senior population. Many rural or remote areas, which often depend on industries such as fishing and mining, are currently experiencing out-migration by young people seeking employment. At the same time, these communities are seeing a rise in their seniors' population, which is less mobile. For these economically poor areas facing low population growth and a declining tax base, funding seniors' services is becoming a greater challenge. The large distances between communities also increases the cost of providing services as it is more difficult to share resources. Moreover, the regionalization of health and social services, happening in many parts of the country, can exacerbate the problem if there is no redistribution of resources based on service needs from higher levels of government to the communities.

Small populations combined with large distances between communities can result in seniors' isolation, particularly during periods of bad weather. If public transportation is available at all, it may be infrequent and on an inconvenient schedule. The average rural resident is 10 km from a physician as compared to less than 2 km for the average urban dweller. Seniors living in rural and remote areas are more likely than their urban counterparts to live in older homes in need of considerable ongoing maintenance and repair. This can be an additional expensive and difficult-to-manage burden.

Approximately 80% of Canadian seniors live in urban areas. In 1995, nearly one third of all Canadian seniors lived in the country's three largest metropolitan areas: Vancouver, Toronto, and Montréal. They comprised more than 10% of the population of each of these three metropolitan areas. In the coming decades, it is expected that the elderly population of suburban areas will grow as their own residents age.

Although access to services tends to be better in urban and suburban areas, other aspects of urban life are often less desirable. Seniors tend to live in the centre of cities where the cost of living is higher and crime and other social problems are more serious. This can undermine seniors' financial security and their sense of safety and security. Another specifically urban problem is the loneliness many people experience because of greater difficulty in developing familiarity with neighbours.

Challenges

- Commit governments to provide adequate resources for health, social, home care and transportation services in rural or remote areas, particularly in areas with a high proportion of seniors.
- Develop innovative ways to increase seniors' access to health and social services, and knowledge about health, for example by using new information technology.
- Create alternative housing and transportation options for seniors in rural or remote areas, and affordable housing options for urban seniors.
- Support community development initiatives in rural and urban areas to reduce seniors' isolation, and to enhance their feelings of safety and security.
- Include provisions in urban development and management for the particular needs of an aging population: sidewalks properly cleared of snow, appropriate lighting, sufficiently long pedestrian walk signals, etc.

Indicators of change

- Increased availability of and access to health and social services by seniors in rural areas.
- An increase in housing and transportation options for rural seniors, and greater housing affordability in urban areas.

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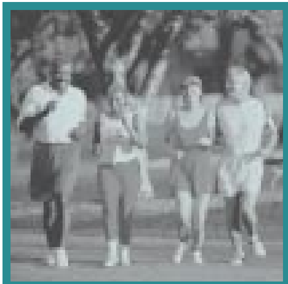
2. HEALTH AND WELL-BEING

2.1 HEALTH STATUS



Issues

Health is not simply an absence of illness. Contemporary views consider health as a positive resource for living and recognize the range of social, psychological, economic, physical and environmental factors that contribute to health. One of the best definitions today is proposed by the Institute of Health Promotion Research at the University of British Columbia; in its view, health is "the capacity of people to adapt to, respond to, or control life's challenges and changes."

Canadian seniors today are living longer lives in better health than in the past. In 1996, life expectancy at 65 was 18.4 years, five years longer than in 1941. Nine of these 18 years are free of disability and the remaining years include 3 years each of slight, moderate and severe disability. Recent gains in life expectancy at age 65 have been largely accompanied by an increase in the number of years spent with slight or no disability.

Disease in later life is more often chronic than acute. Chronic diseases become more prevalent with age. However, most seniors adjust to their state of health and continue to function. In 1995, 78% of seniors aged 65 to 74 and 86% of seniors aged 75 and over living in the community reported having at least one chronic health condition. But these conditions do not necessarily limit seniors' normal activities: only 36% of seniors aged 65 to 74 and 46% of seniors aged 75 and over reported some level of activity restriction because of a long-term health condition. Indeed, despite health problems, the majority of seniors consider themselves to be in good health. In 1995, 76% of seniors aged 65 to 74 and 68% of seniors aged 75 and over reported their health as good, very good or excellent. Even among seniors with complex health problems living in institutions, 43% reported good, very good or excellent health.

A positive perception of one's own health is an indication of a sense of overall well-being that takes into account not only one's problems but, more important, one's capacity to cope with problems; indeed, 85% of seniors with an activity limitation report that they are coping well. Consistent with high perceived health and coping ability is the positive perception of their mental health among the majority of seniors: in 1991, 86% of seniors reported they were very or fairly satisfied with life. However, a similar proportion of seniors (46%) as adults aged 45 to 64 (50%) reported high stress levels due to major life events.

This generally positive picture hides significant inequalities in health among seniors. The physical health status and the mental health status are both heavily influenced by social, economic and behavioural factors throughout life. Seniors with less education and from lower socio-economic levels experience more disease, a shorter life expectancy and poorer emotional well-being. Social and economic factors also influence individual lifestyle behaviours, such as tobacco use, nutrition and physical activity, which in turn are closely related to health outcomes. Seniors' health is linked as

well to social support: seniors with strong social networks, who feel useful to society and participate actively in it, have lower mortality and better physical and mental health.

Health also varies by gender: women suffer from chronic diseases more than men, and make greater use of health care services. Men suffer more frequently from fatal illnesses. Finally, there are also differences among ethnic and cultural groups. Blacks are more likely to die young than whites, but those who reach old age generally live longer than whites. Alzheimer's disease is very rare among Aboriginal peoples in Canada. Decline is not always inevitable: seniors can keep their health and very often improve it.

Challenges

- Devote a greater proportion of public investments to addressing the determinants of health and hold governments accountable for improvements in the social, economic, physical and environmental conditions that determine the health of Canadians.
- Establish collaboration among all sectors of society, including governments at all levels, the private and voluntary sectors and local communities, to strengthen the determinants of health.

Indicators of change

- Increase in the length of life free from disability.
- Reduction in disparities in physical and mental health status among seniors.

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2.2 CHRONIC DISEASES

Issues

As people age, they become more susceptible to many chronic diseases and health conditions, but most seniors adjust to changes in their health and continue to function successfully. The most common conditions are heart disease and stroke, cancer, arthritis, diabetes, osteoporosis, dementia, incontinence and loss of sensory functions. Although the specific causes of many of these diseases/conditions are not known, risk factors can often be identified. Risk factors are not causes of disease but are characteristics, exposures or activities that appear to have some relationship to the development of the disease. These can include factors such as family history, occupational and environmental exposure to chemicals, smoking and obesity. Many chronic diseases have a higher incidence among people with lower incomes.

As research provides insight into the prevention and treatment of chronic diseases, individual seniors may not develop a chronic illness, or may develop it at a later age than at present. Nevertheless, because there will be many more seniors overall, the total number of people with chronic diseases will likely continue to rise and people may live longer with chronic diseases as life expectancy increases. Moreover, there will probably be more people who were affected by developmental disabilities earlier in their adulthood surviving to old age. Investments in the care and treatment of chronic conditions will allow more Canadians with these conditions to enjoy a better quality of life during their senior years and to be able to contribute longer to society.

Much research into aging-related chronic diseases has been undertaken in the last 10 years which has resulted in new treatments and new preventive strategies. Researchers have also found new clues to the causes of these diseases. New drug treatments have been developed to prevent or delay the onset of some chronic diseases. For example, the use of bisphosphonates for the treatment of osteoporosis can increase bone mass which reduces the risk of fractures for postmenopausal women who are not being treated with estrogen. New and improved surgical techniques are being developed that can increase the quality of life and longevity for seniors (for example, surgical implants for seniors with incontinence). Public awareness about the importance of early detection has led to increased use of screening procedures such as mammography for breast cancer. There has been measurable success in reducing the mortality rate for some diseases.

1. Heart disease and stroke

Cardiovascular disease (primarily ischemic heart disease and stroke) is the leading cause of death in Canada. However, its incidence has significantly declined due to technological advances, improved personal health practices and environmental conditions. In 1995, the percentage of deaths caused by cardiovascular disease was 37.2% for men and 32.5% for women aged 65 to 74. This increased to 45.1% for men and 51.2% for women aged 85 and over. Cardiovascular diseases are largely preventable.

The major risk factors identified for heart disease and stroke are elevated cholesterol, smoking, hypertension, family history and three interrelated factors: obesity, physical inactivity and diabetes/ glucose intolerance.

The risk of developing these diseases increases with the addition of each risk factor. Even moderate changes in lifestyle can significantly reduce their incidence.

2. Cancer

Cancer refers to the abnormal, uncontrolled division of body cells which results in a malignant growth or tumour. Over 70% of new cancer cases and over 80% of deaths due to cancer occur among those 60 years of age and over. The most commonly diagnosed cancer among women is breast cancer. Prostate cancer is the most commonly diagnosed type of cancer among men. Lung cancer, however, is the leading cause of cancer death for both sexes.

Risk factors vary by type of the cancer. However, modifiable risk factors have been identified with several cancers. These include smoking, high fat/low fibre diet, insufficient consumption of fruits and vegetables, and a sedentary lifestyle. Other risk factors are specific to the site of the cancer. For example, sun exposure is linked to skin cancer, alcohol is linked to liver cancer, chewing tobacco is linked to mouth cancer, and family history is linked to breast cancer.

3. Arthritis

Osteoarthritis (usually referred to as arthritis) causes the wearing down of joints and cartilage and limits mobility. It is one of the most common disorders and a leading cause of disability among seniors. The most common joints affected are the hands, feet, knees, hips and spine. It is estimated that more than 80% of the population over the age of 75 is affected by arthritis.

Some major risk factors for arthritis are obesity, predisposing diseases and repeated, high intensity stress on joints for extended periods of time. Heredity is also a suspected risk factor.

4. Diabetes

Diabetes is a chronic disease characterized by excess blood sugar. This occurs when the pancreas does not produce sufficient levels of insulin to regulate the blood sugar levels or if the insulin produced is ineffective in reducing the blood sugar levels. Type II diabetes (also known as non-insulin-dependent diabetes) occurs more frequently in adults and is the most common type of the disease, accounting for about 92% of diabetes in seniors. The prevalence of diabetes in 1991 was estimated at about 10% in seniors, and up to four times higher in Aboriginal seniors. It is estimated that for every diagnosed case of diabetes there is one undiagnosed case. Diabetes is a growing problem among First Nations seniors. Greater numbers of Aboriginal seniors are developing diabetes, suffering and dying from this disease and its complications.

Risk factors for diabetes include obesity, a sedentary lifestyle, heredity and a poor diet (low in fibre, and high in calories, sugar and fat). Limited access to fresh, varied foodstuffs in remote regions increases the risk of diabetes for people living there.

5. Osteoporosis

Osteoporosis is a chronic disease characterized by low bone mass and structural deterioration of bone tissue. This increases susceptibility to hip, spine and wrist fractures. It has been estimated that approximately 70% of all fractures among those over the age of 45 result from osteoporosis. Initial results from the 1996-97 Canadian Multicentre Osteoporosis Study report prevalence rates for osteoporosis ranging from 20% for women aged 60 to 69 to 42% for women over age 79, and 13% for men aged 60 to 69 to 30% for men over age 79.

Risk factors for osteoporosis include smoking, excessive use of alcohol and caffeine, reduction in estrogen level caused by menopause, low levels of physical activity, incomplete diet (e.g. low in calcium and vitamin D), predisposing medical conditions and heredity.

6. Dementia

Dementia affects approximately 8% of all people aged 65 and over and between 25% and 30% of persons aged 80 and over. It is estimated that about 20% of day centre clients and more than 50% of residents of long-term care facilities suffer from some form of dementia, and Alzheimer's disease accounts for 64% of all cases. Alzheimer's disease, a degenerative disease of the brain, is the leading cause of dementia. Its symptoms include memory loss, mood and behaviour changes, and deterioration in judgment and reasoning. However, a definitive diagnosis can be made only following autopsy. The Canadian Study of Health and Aging estimated that in 1991 there were approximately 161 000 cases of Alzheimer's disease in Canada and that the number of cases could reach 238 000 by 2001. Risk factors for Alzheimer's disease reported by this study include family history of the disease, head injury, low educational level and occupational exposure to glues, pesticides and fertilizers.

Dementia is a major challenge for families and the community services sector as they strive to keep seniors in a familiar environment while making sure that caregivers are not exhausted by the task, particularly as the number of individuals with dementia could triple by 2031.

7. Incontinence

This condition refers to the involuntary loss of bladder and/or bowel control. It is very common in seniors and is a major cause of institutionalization. Urinary incontinence is more common in women than men. In Canada, it is estimated that urinary incontinence affects 95 000 men and 250 500 women 65 years and over, and faecal incontinence affects 22 000 men and 67 000 women 65 years and over. Incontinence can be caused by, or is associated with, many different medical conditions such as hormonal and anatomical changes in the pelvic organs in women, prostate disease in men, and stroke, neurological and musculoskeletal conditions in both men and women.

8. Sensory problems

Seniors may have vision problems that cannot be corrected by glasses. In 1995, 8% of seniors in the community reported that they could not see well enough to read, even with glasses. Vision problems are more common in institutions where 28% of seniors could not see well enough to read. Senior women are more likely to have vision problems than senior men. Vision problems also increase with age. Hearing problems present challenges to seniors

as well. In 1995, 6% of seniors could not follow a conversation even with a hearing aid. The frequency of hearing problems rises with age.

Challenges

- Promote multisectoral collaboration to address the social and economic conditions that contribute to risk for disease associated with later life.
- Develop, implement and maintain health promotion programs to encourage lifestyle changes to reduce or delay the incidence of chronic disease among seniors and to minimize their consequences if they occur.
- Provide the additional health and social services that will be required, as the population ages, to meet the needs of the increasing number of people with aging-related diseases and to support their caregivers.
- Ensure the early detection and treatment of age-related diseases through better training for physicians and other health professionals.
- Support further research into the cause and treatment of these diseases, including the interaction of genetic and environmental risk factors.
- Maintain autonomy and independence of seniors suffering from chronic diseases which limit daily activities.

Indicators of change

- Additional health care resources targeted to the needs of seniors with chronic diseases and their caregivers.
- Improvements in modifiable risk factors, including reductions in levels of smoking, excessive drinking and obesity, higher levels of physical activity and healthier diets.
- Increase in early detection and treatment of chronic diseases.
- Decrease in incidence rates of chronic diseases among seniors.
- Decrease in percentage of seniors with activity limitations reporting unmet needs for assistance.

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2.3 FALLS AND INJURIES

Issues

According to 1994 data, it is estimated that some 9% of Canadian seniors suffer injuries in a year. Of those who are injured, 88% see their family physician and 28% are hospitalized. More than half of all the injuries are caused by falls, and the most frequent injuries are fractures, sprains and strains. Falls account for 84% of injury-related hospital admissions.

One particularly debilitating type of fracture due to falls is a broken hip. One year after suffering a broken hip, 40% of seniors are still unable to walk without assistance, and 60% have difficulty with at least one essential activity of daily living. In addition, 20% of these seniors, most of them women, go into a long-term care institution for the first time following such an injury.

Injuries therefore have an enormous impact on seniors themselves and on their families and are expensive for the health system. They often lead to an irreversible decline in independence and to placement in a health care institution. However, many of the injuries are the result of preventable accidents. A recent study estimates the total cost of injuries to Canadian society at $8.7 billion annually and almost $1 billion of this is spent on treating falls among seniors.

Injuries occur as a result of a combination of personal or environmental factors. Personal factors include diminished muscle strength, impaired vision, poor balance and chronic conditions. Environmental factors include poor stair design, cracked or icy sidewalks, poor lighting, slippery floors, poorly maintained walking aids and equipment. It is estimated that 14% of broken hips among seniors are attributable to the use of long-acting sedatives, and that an unsafe environment is a factor in from one third to one half of falls. Injury prevention therefore calls for a multidisciplinary, intersectoral approach, both on the individual and community levels.

Challenges

- Increase awareness among people, both seniors and the general public, that many injuries can be anticipated and prevented through personal and community initiative.
- Involve and empower seniors so they see themselves as having an active role in the prevention of injuries and not simply as victims of the problem.
- Encourage government policy makers and communities to adopt a broader vision of injury prevention that encompasses both personal and collective responsibility (e.g. home construction and furniture, sidewalk and public transportation design).
- Establish action strategies to help prevent injuries to seniors, with the partnership of community leaders, voluntary sector, seniors organizations, professionals (e.g. architects, urban planners) and researchers.

Indicators of change

- Increased resources for action strategies to prevent injuries.
- Decrease in the percentage of physician visits and hospitalizations by seniors due to preventable injuries.

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2.4 MENTAL HEALTH

Issues

Mental health refers to the ability of individuals to feel good about themselves, interact positively with others and not engage voluntarily in actions that might cause harm to themselves or others. It is directly related to the ability to continue to function autonomously within the community and to achieve a certain level of fulfilment and satisfaction out of living. People with higher levels of education and holding high social status have better levels of mental health. People with physical health problems or financial insecurity are at greater risk for poor mental health.

The most common mental health problem is depression. It is estimated that about 3% of Canadian seniors living in the community report some symptoms of depression, and U.S. studies have estimated that between 30% and 40% of those living in institutions suffer from depression to some degree. Depression is often underdiagnosed and undertreated because it is confused with or masked by other problems, or because the observed symptoms are considered to be part of the normal aging process. Unlike in younger adults, depression in seniors is more often expressed by anxiety, agitation, and complaints of physical and memory disorders. Considerable experience and expertise are needed to make the proper diagnosis, especially since the wrong diagnosis can have serious consequences. A depressed person might be identified as having dementia, and/or no appropriate treatment might be proposed.

Antidepressants have so far been the preferred treatment despite the side effects, such as the risk of falls. There are few nonpharmacological alternatives, aside from psychotherapy, which is an entirely appropriate, effective treatment for depression. However, such psychotherapy may be provided by health care professionals other than physicians, and is not always covered by private or public health care plans. There are numbers of things that individuals can do to help prevent depression. Sufficient sleep, good nutrition and exercise can all help. Increasing the number of pleasant activities each day can help counteract the impact of unpleasant events. Social contact with people who bolster one's self-esteem can also help.

As in other age groups, declining quality of life, social exclusion and loss of dignity can lead seniors to commit suicide. In 1993, suicide claimed 14 of every 100 000 seniors in Canada; this rate is comparable to that of the 15 to 24 age group. The incidence of suicide among seniors has declined since the early 1980s, when 18 suicides were reported per 100 000 people aged 65 and over. The suicide rate is much higher among male seniors (24 per 100 000) than among female seniors (6 per 100 000). Poor physical health, financial insecurity, loss of a partner, living alone and social isolation are factors contributing to mental health problems which may lead to suicide.

Cognitive disorders also constitute a common mental health problem among seniors. Some cognitive disorders are temporary and can be treated, whereas others, such as dementia, are irreversible.

An accurate diagnosis is essential, because the nature and severity of the disorder can determine whether the patient can continue to live safely and independently. Individuals with cognitive disorders often have behavioural problems that can be alleviated or corrected by medication or by environmental or behaviour modifications. But the medication has side effects that can diminish quality of life even more. As well, prejudice and an inadequate evaluation of cognitive abilities lead to restrictions on individual rights. Forced institutionalization is the most striking example.

One of the major challenges in the years to come will be to provide practical support to the caregivers of seniors with cognitive disorders in order to respect seniors' choice about whether to live in the community or in an institution. The current trend to greater deinstitutionalization may limit the choices available to individual seniors and present challenges for communities in providing necessary support services. Seniors who may be better cared for in an institutional setting may find that insufficient beds are available.

Challenges

- Invest more resources in the mental health sector, which is recognized as the weak link in the Canadian health system. There is a particularly urgent need to develop and strengthen community resources to help seniors with mental health problems (or who are at risk of developing them) and to support the work of caregivers.
- Adjust the staff training, programs and physical environment of long-term care facilities in order to meet the special needs of persons with dementia.
- Increase public awareness about depression and ensure that health professionals receive the necessary training to enable them to recognize and treat depression among seniors.
- Promote nonmedical alternatives for cognitive disorders, for example by modifying the environment to ensure individual safety and through a behavioural approach to treatment.
- Make health professionals specializing in the treatment of mental health problems in older adults aware of the benefits of alternatives to medication in the treatment of depression in seniors, for example, cognitive psychotherapy.

Indicators of change

- Additional resources targeted to increase availability of and access to mental health promotion and intervention services.

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2.5 ABUSE AND NEGLECT

Issues

Since the focus in society on the problem of abuse toward seniors is recent, the way we look at the problem and the knowledge we have regarding it are changing rapidly. A large number of research projects have been conducted since the early 1990s on this subject. However, the absence of a standardized definition remains a barrier to generalization of the various studies on the subject, and identification of cases of abuse. Development of intervention strategies and evaluation of program effectiveness can be hindered as a result.

It is difficult to develop a definition of abuse or neglect toward seniors that will be universally accepted. Some definitions proposed for behaviours termed "abusive" are very broad and include self-neglect and self-inflicted harm. Other definitions, conversely, are very restrictive and include only intentional violent behaviour and mistreatment. To help researchers and workers direct their efforts in a coherent fashion, Health Canada has defined abuse as all of the following: physical violence, psychosocial violence, financial exploitation and neglect. It is estimated that 4% of seniors living in the community have been victims of some form of abuse during their senior years. The most common form of abuse is financial exploitation, followed by chronic verbal abuse. The incidence of physical abuse among seniors is low, according to the literature. Neglect can be either active (intentional) or passive (unintentional) and is characterized by the withholding of items or care necessary for daily living, including adequate heat, clothing, food, hygiene, medical care and the denial of social interaction. Denial of access to grandchildren has also been identified as a form of neglect.

There is little Canadian data which document abuse in institutions. Studies suggest that maltreatment in institutions is, in part, a response to stressful working conditions. In addition to verbal or physical abuse by staff, abuse in institutions can include the inappropriate use of chemical or physical restraints, such as geriatric chairs and sedatives, to manage behaviour problems under the guise of protecting the residents' safety.

Cases of abuse often go unreported. One of the reasons is the extreme difficulty in reaching the victims, especially in the case of people who have a physical or mental disability, or those who are dependent on their abuser and fear possible repercussions, including being placed in an institution. In addition, the victims find it very difficult to admit that their loved ones are mistreating them.

Challenges

- Increase knowledge of this problem by obtaining better national data on the determinants of abuse and neglect, abuse in institutions, and on effective strategies to prevent and remedy the consequences of abuse.
- Increase public awareness of the problem of abuse and neglect, including how to spot abusive situations and how to provide the necessary support.

- Provide shelters that are appropriate for the needs of victims of abuse.
- Provide seniors with information on how to prevent abuse (e.g. whom to ask about the consequences of assigning power of attorney, and whom to make executor of their wills).
- Provide assistance to potential abusers who have psychosocial problems or who react to stress in a violent way (e.g. caregivers who are ill-equipped or lack support for their caregiver role).
- Educate staff in institutions about alternative methods of behaviour management, including social, environmental and psychological approaches, in order to limit the inappropriate use of chemical and physical restraints.

Indicators of change

- Increase in programs for training workers in both the public health field and other fields to improve early detection and intervention.
- Decrease in the percentage of seniors who have experienced abuse or mistreatment.
- Reduction in the use of chemical and physical restraints in institutions.

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2.6 MEDICATION USE

Issues

Advances in pharmacology have led to progress in the treatment of many diseases and a consequent reduction in morbidity and mortality. Drug therapies have cured many individuals and enabled others to live longer, happier and more productive lives.

As a consequence of the advent of less intrusive medical techniques and shorter hospital stays, Canadians receive more medical care and consume more medication in the community than ever before, which increases the risk for medication misuse. Approximately 18% to 50% of drugs taken by seniors are not used appropriately and adverse drug reactions occur in 30% of seniors living in the community.

Prescription drugs can also prevent or replace more expensive institutional care. The increased emphasis on drug therapy may, however, create financial difficulties for seniors with modest incomes if they are not covered by provincial drug plans or have high premiums or co-payments. Some seniors may cease taking their drugs because they can no longer afford them, which could have serious health consequences.

Many chronic or acute diseases tend to increase with age, resulting in an increase in the number of drugs consumed by seniors. In 1994-95, 10% of Canadians aged 65 to 74 years of age and 13% of Canadians aged 75 and over living in the community had taken at least five medications during the two days before the interview. Taking medication may entail certain pitfalls. Inappropriate consumption of several drugs at once, inadequate understanding of the effects of drugs and failure to follow the directions for prescription drugs can place seniors at risk by increasing their vulnerability to injury and illness. Seniors are at particular risk for medication complications due to age-related physiological changes which increase their sensitivity to medication.

Inappropriate prescribing is more common in seniors than middle-aged adults, possibly due to the greater challenges in prescribing for this age group and deficiencies in physician knowledge in this area. Although it is difficult to measure, it is estimated that 25% to 40% of prescriptions are inappropriate. Inappropriate prescribing could involve incompatible combinations of medication, excessive treatment duration or relatively contra-indicated drugs for older age groups.

This inappropriate use of drugs often results in increased costs to the health care system due to a higher number of physician visits and admissions to hospitals and long-term care facilities. Indeed, between 19% and 28% of hospitalizations of patients over the age of 50 are attributable to medication problems.

Challenges

- Require the pharmaceutical industry and others involved in assessing drug safety and efficacy to evaluate more precisely the effect and efficacy of drugs in the senior population.

- Disseminate such knowledge on prescription and over-the-counter drugs to health care professionals and consumers to better control the side effects of using a drug or of using several drugs at once and encourage medical schools to provide adequate training on the risks of polypharmacy in seniors.
- Evaluate the effectiveness of interventions and education programs which aim to modify inappropriate medication-taking behaviour and prescribing practices.
- Urge seniors and physicians, where appropriate, to change their habits and opt for more natural forms of treatment that could be just as effective as certain drugs. Examples of frequently misused drugs are sedatives, minor tranquillizers, stomach pain remedies and laxatives, which could be replaced by a change in habit and diet.
- Develop better means of facilitating patient participation in decision making with regard to their medication and provide information to patients to improve their compliance with their particular treatment.
- Adopt a drug surveillance system containing information on the drugs being taken by an individual, any drug allergies the individual may have, literacy level and other relevant health information that would allow for greater collaboration between physicians and pharmacists in identifying potential problems.
- Implement pharmacare coverage across Canada to provide for medically necessary drugs, both at home and in health care institutions.

Indicators of change

- A reduction in the percentage of seniors using sedatives and tranquillizers, as well as stomach pain medications and laxatives.
- A reduction in hospital visits and physician consultations due to adverse drug reactions.
- Decreased rates of inappropriate prescribing.
- Decreased out-of-pocket expenses spent on medication.

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2.7 HEALTH PROMOTION

Issues

Just as health is more than the absence of disease, so health promotion is more than the prevention of disease: health promotion includes any individual or collective activity intended to maintain and improve the physical, psychological or social dimensions of health. Health promotion strategies are effective in laying the foundation of robust health in youth and mid-adulthood that continues into the senior years. They are also effective in reversing declines in health and functional ability in later life, declines that are mistakenly thought to be an inevitable consequence of aging.

In some ways, today's seniors take as good or better care of their health as younger Canadians. For instance, seniors are less likely to smoke or consume alcohol and are more likely to eat three regular meals a day and to have their blood pressure taken. The lifestyles of younger Canadians are more health promoting in other ways, suggesting that tomorrow's seniors may be healthier than today's. For example, Canadians under 65 are better informed about health issues, more inclined to want to change their behaviours in order to improve their health, more likely to have Pap smears or mammograms and somewhat more likely to engage in regular physical exercise.

Social, educational, economic and environmental factors influence individual health behaviours to a large extent throughout the lifespan. To illustrate, good nutritional habits are determined by education, income and social integration. Another determinant of health practices is self-esteem: people who feel good about themselves are less inclined to engage in self-harming behaviours and are more confident that they can make a positive difference in their well-being. Gender shapes health behaviours as well: men are more often engaged in physical exercise than women, but women are better informed about health matters and more inclined to undergo preventive screening.

Promoting healthy aging means taking action on the broad determinants of health throughout the life cycle and paying special attention to groups that are particularly vulnerable with respect to these determinants. Among seniors, these vulnerable groups include persons with low income (many of whom are women living alone), those with low education or literacy and seniors who are socially isolated owing to geography, marital status, advanced age, or language or cultural differences. Effective health promotion activities for seniors take a holistic approach which recognizes the many determinants of healthy lifestyles, often including social activities and recreation and engaging the beneficiaries in taking charge of the program to build their self-esteem.

More and more Canadians are becoming interested in alternative medicine, both to promote good health and to cure or control a health problem. For many Aboriginal seniors and seniors from Asia and the Middle East, so-called "alternative"

therapies or remedies are the traditional healing methods of their culture. Although making use of these therapies reflects a positive and active approach to caring for one's health, most of these therapies and products have not been tested for their safety and efficacy. Little is known about the effects of combining herbs or other "natural" remedies with conventional drug therapies. As well, there are no standards governing the practice of alternative therapy nor for the production, distribution and advertising of alternative remedies.

Challenges

- Establish national health goals and accountability mechanisms to spur action by governments, communities, the private sector and individuals on the broad determinants of the health practices of Canadians of all ages.
- Provide ongoing and substantial support at the federal, provincial/territorial and local level for health promotion initiatives that empower individuals and communities to improve health practices, including wellness clinics.
- Make health information readily accessible and attractive to a wide audience, encouraging creative approaches to connecting with groups who are hard to reach.
- Conduct research on alternative therapies and remedies. Based on the findings, establish quality and safety standards, professional training norms and information guidelines to ensure the safe and effective use of these approaches.

Indicators of change

- Average increase in the proportion of life free from disability.
- Increased percentage of seniors engaging in healthy lifestyles.

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2.8 PALLIATIVE CARE

Issues

The provision of high quality care at the end of life is a growing concern among Canadians. Care at the end of life is of particular interest to seniors and their families because the highest proportion of deaths (75%) occur among older adults. It is an important issue for the health system, because care in the last months of life engenders the highest costs to the system and because the demands for comprehensive home care services for people with terminal illness are increasing. Finally, care at the end of life raises significant ethical and legal issues for society as a whole, including legal recognition and use of advance health directives and controversy about whether the right to a dignified, compassionate death should include deliberately hastening death, with or without the express consent of the individual. These ethical issues are discussed in section 3.6.

Palliative care offers the relief of pain and other symptoms; it seeks to meet not only the physical needs but also the social, psychological, emotional and spiritual needs of persons with terminal illness, their families, caregivers and other loved ones. Thus, the health and well-being of the patient and her or his caregivers and loved ones are enhanced. Informal caregivers (i.e. family, friends, volunteers) are given advice on providing palliative care, offered respite, and supported through bereavement following death of their loved one.

Palliative care can be provided at home, in hospital, in long-term care facilities, or hospices. Ideally, palliative care is provided through a team approach involving informal caregivers and a range of multidisciplinary professional caregivers, such as nurses and spiritual counsellors. It can be provided simultaneously with treatment, or after the decision has been made to end curative treatment measures.

There are a variety of barriers impeding the provision of high quality, patient-centred and patient-controlled palliative care. Payment for palliative care services is influenced by the setting in which care is provided. There are variations in the extent to which home-based palliative care is available, and is funded by provincial/territorial governments. Eligibility criteria and the range of services available also vary within jurisdictions, and from one jurisdiction to another. Patients with higher economic status are more likely to receive palliative care and to die at home in accordance with their wishes than are poorer patients. Seniors, particularly the very old, may lack the social supports necessary for the provision of informal care. Not enough is known in a variety of areas: for example, the meaning of death and dying to seniors, and how to provide effective pain management for seniors experiencing the symptoms of several health conditions simultaneously. The fears and concerns of seniors may be discounted based on the belief that "they have already lived long lives." Finally, medical science's curative focus leads some health care professionals to view palliative care as an admission of "failure," increasing their reluctance to offer palliative care services.

Challenges

- Integrate palliative care, especially home- and community-based palliative care, in the continuum of publicly funded health care services in accordance with the principles of the *Canada Health Act* (accessibility, portability, comprehensiveness, universality, and public administration).
- Ensure choice and control by seniors over the setting in which their palliative care is provided, and the types of services available, without barriers based on geography, economic status, etc.
- Develop, implement, evaluate and share information on a range of palliative care delivery models and clinical practices that respond to needs associated with different illnesses of different age groups (e.g. palliative care needs of an older patient with Alzheimer's disease differ from those of a younger patient with breast cancer).
- Provide ongoing training, emotional support and respite to palliative care providers, both professional and nonprofessional.

Indicators of change

- Increased training and support for palliative care providers.
- Increased patient, family and caregiver satisfaction with palliative care.
- Increased availability and funding of palliative care.

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2.9 HEALTH REFORM

Issues

At its inception in the early 1970s, Canada's health care system was oriented to curing illness through hospital care and medical services. Dramatic technological and professional evolution, changing demographics and cost pressures have all combined to challenge the way health care in Canada is funded and delivered. Although the changes to the health care system have been pervasive and complex, most of the change has taken the form of downsizing and administrative restructuring (e.g. regionalization of health services in most provinces and hospital consolidation). Actual reform itself, in the sense of implementing new and improved systems and processes of service delivery, is still in its early stages. Moreover, provinces vary enormously in the rate and type of reforms undertaken, and changes are still in progress in provinces where reforms have gone the furthest (Alberta, British Columbia, Saskatchewan, Quebec, New Brunswick and Prince Edward Island). For this reason, it remains difficult to fully describe or compare health care reforms. Changes so far have reduced overall health care costs from 10% to about 9% of Gross Domestic Product. However, evaluation of the impact of these changes on health outcomes is only beginning.

The health system issues that all jurisdictions are addressing, each in its own way and at its own speed, are presented below with a few examples:

- A broader perspective on health: increased emphasis on wellness and disease prevention and increased emphasis on influencing social, economic and environmental determinants of health.
- Systems harmonization: consolidation of acute care services; integration of service sectors such as social and health, or community and long-term care.
- Organizational change: regionalization and major restructuring and downsizing of departments and ministries of health; client-centred care through single entry point and case management.
- Public administration: regional service management, delivery and accountability; greater representation of the community in decision making.
- Changes in management practices: focus on information systems and informed decision making; evidence-based decision making, need to demonstrate value for money; emphasis on identifying and adopting best practices.
- Renewed emphasis on quality: increased emphasis on quality assurance, accreditation, clinical practice guidelines and care maps.

These initiatives should lead to more effective, responsive health care for all Canadians. Nevertheless, Canadians are not convinced that the system is moving to provide them with better, more efficient care: they are disturbed by reports of hospital closures and of excessive waiting times for

services, such as specialist care, emergency hospital care and long-term institutional placement, as well as reports of gaps in service. There is political pressure in some provinces to "turn back the clock" to counter the perceived erosion of the health system by reinvesting government budget surpluses back into hospitals. There have been calls as well to allow the development of a privately funded health system to give people choice and unclog the public system. Without a clear public accounting of the effects of these reform initiatives on the quality of care and health outcomes, these pressures will continue.

Cost-cutting imperatives superimposed on system reform efforts may have undermined the potential benefits of the reform. For instance, hospital downsizing has not been accompanied by a sufficient expansion of home care. Although provincial budgets for home care have doubled in recent years, this sector represents only 4% of provincial health care expenditures. Additional evidence of insufficient public funding for home care is the growth of privately purchased home care services to provide care to people not eligible for publicly funded home care or to people who wish/need to complement the public services they receive.

The decrease in public funding and concomitant growth in private payment is evident in other areas as well. From 1975 to 1994, per capita public health expenditures (expressed in constant 1986 dollars) decreased from $837 to $451, while private per capita expenditures rose from $297 to $491. Technological and structural changes have shifted care from the hospital to the community and from physicians to other health professionals. Out-of-pocket or private insurance payments for health care have increased, because services are less likely to be fully publicly insured if they are not provided in hospitals (e.g. drugs) or by physicians. Out-of-pocket health expenditures by seniors for drugs have risen because increasing drug costs have led all provinces to charge or to increase co-payments within drug benefit plans. Recognizing that preserving and protecting medicare means adapting to new realities, the National Forum on Health told governments to "fund the care, not the site" and recommended that publicly funded services should be expanded to include home care and drugs.

The advice of the Forum reflects as well an understanding of health services that is becoming more inclusive than the "medically necessary" services currently insured under the *Canada Health Act*. For instance, the Canadian Public Health Association has recommended replacing the concept of "medically necessary" services with "health necessary" services, meaning those services which result in the greatest health gains for individuals and communities. This concept is consistent with NACA's view that the definition of health services should take global health needs into account. This comprehensive understanding implies the inclusion of a much broader range of sites, health care providers and services within a publicly funded system. Services would cover the entire health spectrum, including disease prevention, health promotion and the full range of home care/home support and institutional services for restoration, and chronic and palliative care. The notion of a continuum of care not only is the best fit for today's and tomorrow's health technology, it is also the best model for responding to the health needs of an increasing population of seniors. An

added advantage of bringing all health-necessary services under the same public umbrella in every jurisdiction is that it would eliminate disparities between jurisdictions in access to many non-insured health services.

Developments in communication and information technologies and their application to the health sector will play a large role in integrating and expanding health services. For instance, the development of telehealth services will significantly reduce long-standing service gaps in rural areas. They will also assist in determining the most effective and efficient ways to organize and deliver care. Having electronic patient records will make it possible to have services that follow the person rather than having the person follow (or rather chase) the services.

Challenges

- Implement public accountability for health care requiring regular evaluation and report to Canadians regarding the quality of care and health outcomes.
- Develop and implement information and communication systems to support the expansion and integration of services and the monitoring of health system performance and health outcomes.
- Reinvest and reallocate public resources in health to accelerate the development of fully integrated, client-centred delivery systems that are effective, responsive and efficient.
- Extend the publicly funded health care system to cover all types of home care and drug care and eventually to provide all services necessary for health, with national service standards.

Indicators of change

- Improved public confidence in and support for the public health care system.
- Improved evaluation of health system performance.
- Improved availability of and access to all services necessary for health.

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3. MAINTAINING AUTONOMY

3.1 FAMILY AND OTHER INFORMAL CAREGIVERS

Issues

Recent changes in the health and social services system have strained the ability of community services and the informal support network to provide adequate assistance. Limits on institutionalization, shorter hospital stays and the growing reliance on ambulatory care have increased the need for home care.

Informal caregivers are a vital resource in the health care system; they provide about 80% of all home care to seniors living in the community and up to 30% of services to seniors living in institutions. The burden of providing care often rests with private individuals and families, beginning with spouses, and this may ultimately have a detrimental effect on the health of these caregivers. In 1996, 29% of caregivers of persons with long-term health problems stated that caregiving had altered their sleep patterns and 21% claimed that their health had been affected. While the majority of caregivers have a very positive impression of their activities, about half report that caregiving has had repercussions on their jobs (lateness, absenteeism) or forced them to incur additional expenses.

If the objectives and specific functions of the health care system do not include support to caregivers, such support may come too late or be insufficient to prevent caregivers from suffering burnout. Since caregivers are key players in home support services, they must be recognized as legitimate beneficiaries of home care services, by ensuring that they have opportunities to receive training, supervision and respite services. It should be noted, moreover, that some caregivers are reticent to use available support programs.

Caregiver burden occurs when there is a wide range of complex tasks and the caregiving is unevenly distributed among the caregivers; this has a negative impact on both the personal life of the primary caregiver and the quality of the care provided. The burden is even heavier when the primary caregiver lives with the dependent person and must coordinate and organize case management.

The increased life expectancy and relatively high fertility of the parents of baby boomers point to the possible strengthening of family ties in the near future. In the long run, however, future cohorts of seniors will not have such large families that they can turn to for personal care, and may be more dependent on government services. Networks of friends could make up for the reduced family network, although it is generally recognized that some types of care (e.g. taking a bath) require the kind of closeness that stems from family ties, and rarely from close friendship.

Challenges

- Provide community services that improve informal care so as to enable caregivers to provide care for a longer period of time, and limit overwork and fatigue.

- Increase employer flexibility and have them adopt policies that recognize their employees' responsibilities for all family members who require assistance or special care, including an aged parent. All special provisions for child care benefits relating to the care of a dependent child should also apply to care for a dependent senior.
- Amend the provisions of the Quebec Pension Plan and the Canada Pension Plan to make the "drop-out period" used in the calculation of pensionable earnings reflect the time spent supporting seniors who require constant assistance in their activities of daily living.
- Find better ways of providing respite services to informal caregivers so that they might use this service more often.

Indicators of change

- Increased use by caregivers of support and respite services.
- Increased funding of home care and community care services that reduce the burden on families.
- Increased number of workplaces with "family-friendly" policies that allow workers to balance work and caregiving obligations.
- Decreased extent and severity of perceived burden reported by informal caregivers.

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3.2 HOME CARE AND HOME SUPPORT SERVICES

Issues

Recent funding cuts to acute hospital care and residential long-term care, and a shift in philosophy favouring community-based care over institutional care have increased the demand for home care. This demand will continue to rise in the coming decades as the number of seniors, particularly oldest seniors and those with complex health conditions such as Alzheimer's disease, increases. As people age, they are more likely to require some support to maintain independent living. Older seniors are three times more likely to use home care than younger seniors. Seniors rely most heavily on home care services related to personal care, housework and meal preparation to deal with limitations imposed by chronic health problems (e.g. arthritis). Younger age groups, on the other hand, rely most heavily on nursing care to deal with acute health problems.

A variety of publicly funded health care and support services can be provided to individuals in their homes to meet their medical and daily living needs. These services can include assessment and case management, nursing, physiotherapy, occupational therapy, homemaker services and meal programs. These services help people with varying degrees of disability to live in their own homes, and can prevent or delay the move to long-term care or acute care facilities. Home care provides support to those who have chronic conditions, who need support upon discharge from hospital, or who require palliative care.

During the 1997-98 fiscal year, public home care expenditures amounted to nearly $2.1 billion, up from $1.1 billion in 1990–91. This $2.1 billion represents 4% of total public health spending in Canada, up from 2.3% at the start of the decade. The provinces provide the bulk of this funding, with all provinces funding some home care services, but the need for these services continues to grow. Because home care is not insured under the *Canada Health Act*, individual provinces may choose whether or not to fund the services. Therefore, there are major disparities in the types of services provided among provinces, and between rural and urban areas. Furthermore, there is no portability of services between provinces.

There are frequently financial challenges faced by seniors as they move from care in a hospital to home care. For example, medication is provided free of charge while in a hospital but not while under home care.

Publicly funded home care represents a small percentage of all home care services provided in Canada, with approximately 80% being provided by unpaid informal caregivers, usually family and friends who are primarily women.

Consultations by the National Forum on Health show that there is public support for government-funded home care using professionally trained personnel. This is based on the belief that home care is an effective and often more economical way of promoting recovery

and well-being, while relieving families and friends from an undue burden of care for their loved ones.

Challenges

- Develop home care programs across the country that are part of an integrated range of health services that meet the principles of the *Canada Health Act* (accessibility, portability, comprehensiveness, universality and public administration) and that provide high quality services to seniors and others.
- Ensure access to services in rural and urban communities.
- Recognize that seniors must be full participants in policy and program development, implementation and evaluation concerning home health care.
- Develop and implement a variety of effective, cost-efficient models of home care.
- Guarantee a flexible range of home care services that meets the diverse physical, emotional, cultural and social needs of seniors and their formal and informal caregivers, including needs related to physical and mental disabilities, culture and respite care.
- Balance the human and financial resources in the home care system to address needs related to chronic conditions, which seniors are more likely to have, and those related to acute conditions more likely in younger populations.
- Build an integrated community-based home care program that recognizes and supports informal services as well as formal ones.

Indicators of change

- Development of home care service standards that are consistent across Canada.
- Increased funding for home care services and decreasing out-of-pocket expenses spent on home care.
- Decreased percentage of seniors with unmet home care needs.

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3.3 LIVING IN RESIDENTIAL CARE FACILITIES

Issues

Since 1986, the proportion of seniors living in a hospital or other health-related institutions (e.g. special care centre for the elderly or the chronically ill) has gradually decreased, from 7.5% in 1986 to 6.8% in 1996. This decrease is partly due to social policies that have, over the past 20 years, resulted in a significant shift toward family and community resources by limiting institutionalization of seniors and by facilitating at the same time the development of home care services. There has also been a decrease in the rate of admission to institutions of seniors with less serious problems, resulting in the admission of individuals who on average require a higher, more intensive level of care than the earlier clientele.

Approximately 85% of seniors in institutions are over age 75, and a majority are women. Chronic health problems such as Alzheimer's disease and other forms of dementia (reportedly affecting one third of residents), incontinence and the aftermath of stroke are more common in seniors living in health care institutions than in seniors living in the community.

Even if increasing emphasis is placed on long-term care provided in the community, it is likely that the need for beds in institutions will continue to increase in tandem with the increase in the number of people who are very old. Despite the decrease in the rate of institutionalization, the number of seniors in institutions rose from 203 000 to 240 000 from 1986 to 1996. If, as is expected, more and more seniors reach the point where institutionalization is required, it will be necessary to ensure that beds are available.

In recent years, the philosophy concerning the aims of long-term care has changed. It is now recognized that it is as important to meet people's psychological, social, cultural and spiritual needs as it is to meet their physical needs. It is also accepted now that more attention should be paid to individual rights and freedoms through emphasis on the individual's autonomy and empowerment, and through service delivery that is person-centred. However, it must be admitted that much work remains to be done in the application of these principles.

It is true that the insufficient number of employees in institutions can result in care being provided in a rigid, routine and impersonal way. It is also true that training for professionals employed in long-term care institutions is often quite limited and undervalued. The fact remains that, too often, institutions are operated on the basis of the staff's needs and of the organization of the work rather than on those of the residents. The basic challenge is to transform long-term care from an institutional focus to a focus on the resident.

Challenges

- Ensure that the trend to limit long-term care institutions does not eliminate the places needed by persons too disabled to live in the community, that individuals' financial resources never

become a barrier to access to long-term care institutions, and that the types of institutions meet the various categories of needs (e.g. for semi-autonomous individuals, persons with spouses).

- Respect individual autonomy, enhance empowerment and maximize functional capacity in long-term care facilities (e.g. offering rehabilitation, providing privacy for couples, respecting cultural beliefs and traditions, and facilitating access to the community outside the institutional walls).
- Recognize the more intensive level of care required in long-term residential care; account for this in the organizing and funding of care, the training of staff and the physical arrangement of the premises, while taking into account the needs of clients who do not suffer from dementia.
- Provide information and opportunities for residents and their families to take initiatives and participate in the life of institutions, rather than expecting simply passive cooperation with decisions made by administration and staff.
- Monitor and evaluate the trends with respect to direct charging of residential fees in long-term care facilities, in order to guarantee equitable access and reasonable costs for everyone. The regional disparities that we are now seeing should be reduced.

Indicators of change

- Improved quality of care (e.g. increased staff: resident ratios) and life satisfaction in institutions.
- Shorter waiting lists for institutional placement.
- Reduced out-of-pocket costs for institutional care and greater consistency of private costs across Canada.

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3.4 TRANSPORTATION

Issues

For seniors, transportation represents more than a means of getting from point A to point B. Inadequate and unaffordable transportation options contribute to isolation, undermine independence, and impede access to services and activities.

The most basic means of transportation, walking, can become a problem for some seniors. After motor vehicle accidents, pedestrian safety is the main safety issue for seniors. Seniors accounted for 26% of pedestrians killed in traffic accidents in 1993. For seniors with mobility impairments, particularly those who use walkers, canes or wheelchairs, crossing intersections in a safe and timely fashion can be difficult. This problem is worse in bad weather or when the pedestrian walk signals are too short. Overall, 66% of all collisions involving older pedestrians occur at intersections.

The automobile provides seniors with considerable freedom and convenience. About 70% of Canadians aged 55 and over have a driver's licence. That figure could rise with new generations having a higher percentage of women who drive. Three to five percent of adults 55+ have an automobile accident in a given year. Calculated on the basis of distance travelled, the risks of collision for those aged 75 and over are the same as for high-risk drivers aged 16 to 24. The consequences of collisions are more serious for seniors than for young people: seniors who have car accidents are three times more likely to die than a young person.

Chronological age alone cannot determine someone's ability to drive. Seniors are a diverse group and many remain excellent drivers well into old age. Other seniors, however, may have slower reflexes, chronic conditions such as arthritis, and diminished hearing and vision that can make driving difficult and/or unsafe. The prospect of having one's driver's licence reassessed can be intimidating and may result in loss of self-esteem and confidence, and seniors who lose their licences also lose a degree of freedom and independence. The lifestyle of seniors who lose their licence may have to change completely. These changes can include increased use of public transit in areas where it exists, a move, and changes in shopping, leisure and vacation habits. Taxis are an option only for seniors who can afford them.

Public transit can provide an affordable and convenient means of transportation. However, there is considerable variation in the availability, cost and scheduling of public transit. In some instances, use of public transit may be impractical. A frail individual may feel intimidated and be at risk of injury on a crowded bus.

Many bus companies provide specialized services for people with disabilities. These services can range from driver assistance in boarding the bus to a separate set of buses equipped with devices (e.g ramps, lifts) to assist those in wheelchairs. While people with mobility impairments may have access to specialized services, there are

also a number of "invisible" handicaps for which people require assistance. For example, seniors with lung and/or cardiovascular problems may not have sufficient stamina to use regular public transport but may not qualify for specialized services.

However, as with regular bus service, specialized services are often unavailable to seniors in rural areas. Even when the services are available, travel must be scheduled in advance and there is less convenience than with regular bus service or a private vehicle. The extent to which municipal funding cuts affect the availability of public bus services varies from city to city.

For air and train travel, many carriers provide special rates for senior citizens. Boarding and disembarking assistance are often provided as well as assistance with baggage. In recent years, some structural improvements that accommodate the needs of persons with disabilities have been made to airports, and train and bus stations. Although this trend must continue to make transportation services more accessible, disabilities will remain a barrier to mobility for seniors. In 1991, 20% of seniors with disabilities reported they could not travel long distances due to their disability, and 21% needed an attendant or companion's assistance for a long trip.

Challenges

- Develop road and highway design features, including signage, traffic light timing and curb height, that take into consideration the special needs of people with mobility, visual, hearing and other limitations.
- Assess the competence of older drivers in ways that weigh safety concerns while respecting the dignity and independence of each individual.
- Assess and minimize the negative impact of budget cutbacks to public transportation services on seniors and persons with disabilities.
- Ensure continued improvements to long distance transportation systems for seniors and persons with disabilities.
- Encourage innovative approaches to enhancing transportation in rural areas.

Indicators of change

- Increase in percentage of seniors and persons with disabilities who can travel long distances independently.
- Increased availability of public transportation, especially for rural seniors and persons with disabilities.
- Lower accident rates among senior drivers.
- Fewer pedestrian accidents involving seniors.

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3.5 HOUSING

Issues

The vast majority of seniors (93%) live in private dwellings in the community rather than in institutions (7%). Seniors have a strong desire to live independently and with safety, comfort and security for as long as possible. A relatively large proportion of seniors own their homes. In 1997, 84% of families headed by a senior and 50% of single seniors owned their own homes. Most senior homeowners (84% of families headed by a senior and 89% of individuals) have paid off their mortgage. Also, the quality of seniors' homes is as good as, if not better, than that of others in the community. However, as seniors grow older, their homes often need to adapt to their declining capabilities. As the proportion of seniors, especially older seniors, increases in the population, so too does the need for safe and appropriate housing. Seniors require a broad range of housing options that reflect their personal preferences and meet their physical, mental and social needs.

Options can vary with respect to the type of dwelling (e.g. single-unit house versus multi-unit apartment); tenure (e.g. ownership, rental, condominiums, or coop housing); living arrangements (e.g. living alone, with a spouse, with multiple generations, or with persons who are not relatives); and availability of support services (e.g. homemaking). Housing should enhance the independence of seniors, whether they are fully independent or have varying degrees of dependence on others due to frailty, and conditions such as dementia. Housing should be adaptable and barrier-free (i.e. free of barriers that prevent one from using the environment to the extent of one's abilities). The design should permit the introduction of safety, security, technological and automation features as required. In addition to providing accommodation, housing should facilitate access to health, social and support services. Some innovative housing options for seniors have been introduced, due in part to the programs and publications of the Canada Mortgage and Housing Corporation, but their implementation has been uneven across the country. As well, there is a marked need for the development and application of clear provincial housing standards for the variety of housing options being developed for seniors, particularly those involving group living arrangements.

Affordability is an important consideration for senior home owners who must budget for ongoing maintenance costs and often rising municipal taxes, as well as for renovation of older structures. Reverse mortgages have been introduced to allow homeowners to purchase a tax-free annuity against the value of the home. Despite the attractive features (retaining the home until death and having more income), reverse mortgages involve some degree of risk of which borrowers may not be fully aware. Affordability is also a major concern for renters, many of whom are seniors with lower income levels, who must cope with rising rents. Rent control policies vary across the country, federal funding is no longer available for building new social housing (with the exception of homes for on-reserve Aboriginal people) and, in

some large urban areas with a high demand for housing, the stock of adequate, low-cost rental accommodation has declined.

Challenges

- Educate developers, architects and municipal officials to ensure that new houses and apartments have a "universal" design, appropriate for persons of all ages.
- Promote and support retrofitting of existing housing used by seniors.
- Provide a national insurance program for reverse mortgages to protect homeowners against major losses.
- Ensure the availability of appropriate, affordable rental accommodation, especially in large metropolitan centres.
- Increase the number and range of assisted-independent living options that support seniors with declining physical and/or mental capabilities; examples include small group homes, individual apartments with support services and multi-level housing, combining fully independent, assisted-independent and institutional units on the same site.
- Eliminate barriers to the expansion of housing choices for seniors, including municipal bylaws, lack of public awareness and attitudinal barriers.

Indicators of change

- More homes with safety and convenience features, suitable for residents of all ages.
- Greater range of housing choices to reflect seniors' preferences and needs.
- Increased availability of affordable housing for low- and modest-income seniors.

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3.6 ETHICAL ISSUES

Issues

Aging societies raise many new ethical issues concerning seniors themselves and society as a whole. The issues facing Canadian society are ones that involve common values and therefore concern every member of society. The object of ethics is to make a considered choice that leads to the greater benefit for the most people or, at least, avoids the greater harm. Ethical decision making strives to answer two basic questions:

- WHAT should be allowed, encouraged, tolerated or prohibited?
- HOW should it be decided what is allowed, encouraged, tolerated or prohibited?

The major ethical challenges in an aging society revolve around public policy, individual treatment, and care and research.

1. Public ethics

Public ethics concern society as a whole, in particular public resource allocation and the kind of social policies put in place to support people or to encourage them to act in certain ways (e.g. to influence the age of retirement). Some public pension programs and income tax credits take age as an eligibility criterion, although benefit levels are subsequently determined according to the senior's income. These programs were justified by the notion that aging is a good proxy for need, because aging represents a gradual loss of ability to meet one's own needs. However, more and more people remain in good physical and mental health beyond their 60s and some beyond their 70s. Is age alone still an acceptable criterion of entitlement to a public pension? Should mandatory retirement at 65 be prohibited? How should society view retirement? What are the alternatives?

Although there are different views on the allocation of limited resources to health care, it is commonly accepted that a distinction should be made between age as a medical criterion and age as a factor in decisions about a patient as a person. From an ethical standpoint, there would be objections to discontinuing or denying care to a person on the grounds of age alone. From the same standpoint, however, there would also be objections to persistent efforts to extend the lives of seniors indiscriminately. The principle of equality would apply in the sense that the needs of each senior would be respected; they would never be abandoned and they would be provided with the care appropriate to their general condition.

2. Clinical ethics

Clinical ethics concern individuals' control over their own lives when they are ill and require care. Because illness occurs more frequently as people become older, clinical ethical decisions can have a considerable impact on the care that seniors receive and on the choices regarding care that seniors can exercise. The most common ethical dilemmas have to do with obtaining informed consent for clinical procedures, but other issues can arise, such as withholding or withdrawing treatment or deliberately

hastening death. The importance of establishing and implementing clear and consistent procedures for ethical decision making becomes more pressing, increasing as the sheer volume of older adults receiving health care increases.

To ensure that people retain the right to self-determination when they are ill, health care should be provided only with the free and informed consent of the patient. This means that the individual must feel free to make the decision that he or she believes is best without undue pressure from family or health professionals, and that the person must have received all of the information needed to make a well-thought-out decision, including on potential risks and consequences and on treatment alternatives. Mental competency is a prerequisite for giving consent for health care. When a person is very ill, or has fluctuating levels of competence, there is a risk that his or her right to make his or her own decisions may be disregarded. Similarly, there is a risk of disregarding the person's choice if it runs contrary to the judgment of the family or health professionals. Incompetence should be determined by objective, reliable methods. For those who are incompetent to make decisions regarding their care, individuals designated by law may give substitute consent which must respect the wishes expressed by the person.

The heightened demand for protection of the right to self-determination has led to a demand for advance health care directives. An advance directive is a set of instructions prepared by an individual concerning the medical treatment he or she wants or does not want to be administered in the event that he or she is unable to express his or her wishes. Legal recognition of advance directives varies from province to province. Even where they are recognized, awareness and use of this instrument by seniors is limited.

Respect for a person's right to self-determination does not mean consenting to medically inappropriate treatment, nor does it extend to committing acts currently prohibited by law, such as euthanasia or assisted suicide. The societal debate about the legalization of euthanasia and assisted suicide continues without a clear resolution in Parliament or the courts. While the issue concerns anyone with a terminal illness, older adults are particularly affected insofar as terminal illnesses are more common in later life. Whatever the eventual outcome of the debate on euthanasia and assisted suicide, there is an undisputed need to provide more comprehensive palliative care to allow people to die in comfort and dignity.

3. Research ethics

As the proportion of seniors in society grows, incentives to conduct aging-related research will increase. Ethical decision making in research involves achieving the right balance among the requirements to respect individual self-determination, to avoid harm and to treat all persons fairly. Conducting research with seniors can be ethically somewhat more challenging than research with younger adults. It may be more difficult to obtain free and informed consent, for instance, among seniors with cognitive impairment or who are dependent upon others for care. Seniors may be deemed to be more susceptible to potential harms inherent in some research (e.g. experimental medical interventions or drug trials). While seniors vary considerably in their capacities, some researchers may prefer to "play it safe" and

avoid involving seniors in their research altogether. However, not including seniors in research protocols may violate the principle of justice, either because their right to choose to participate is denied, or because the potential of making discoveries that could directly benefit seniors is missed. The ethically correct decisions will vary case by case: what is clear, however, is that the need for knowledge about aging and seniors will require researchers and research ethics committees to weigh the sometimes conflicting considerations to ensure that seniors participate in research that can benefit them.

Challenges

- Stimulate ethical research and wide public discussions on the following issues of societal concern: the purpose of and entitlements to retirement, the mutual obligations between society and its retired citizens and the implications of legalizing euthanasia and assisted suicide for vulnerable seniors.
- Legally recognize advance health care directives as a means of ensuring patients' rights to self-determination and educate seniors and health professionals in their use.
- Encourage seniors to participate in research and oblige researchers to include in their protocols a fair representation of groups that may benefit from the research.
- Train future health care providers, policy analysts and researchers on ethical issues related to the aging population and end of life.

Indicators of change

- Increased use of advance health care directives.
- Greater training on ethical issues for health professionals.
- Increase in requirement by ethics research committees for the representation of all potential research beneficiaries, including persons age 65 and over, in clinical research samples.

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4. FINANCIAL SECURITY

4.1 FINANCIAL SECURITY AT RETIREMENT

Issues

Seniors have four possible sources of income: government transfer payments, private retirement plans, employment earnings and the wealth they have accumulated in their lifetime. The concept of seniors' financial status seems simple, but it is difficult to measure all of its components and obtain a comprehensive assessment of its adequacy. While income tax statistics provide information on annual incomes, little information is available on the amount of savings accumulated by individuals, the value of their assets, and the wealth of other individuals in the household. The available data, therefore, provide only a partial picture of the situation.

One of the indicators of financial well-being is income level. The proportion of low-income seniors (i.e. those who are substantially worse off than the average) has declined significantly in the last 15 years, from 34% in 1980 to 19% in 1994. More seniors who are alone (i.e. who live alone or with unrelated individuals) have a low income than seniors living in a family situation. In 1994, 48% of individuals who were aged 65 and over and alone were considered part of the low-income group, compared to only 6% of seniors living with a spouse or relative. It is encouraging, however, that these levels were 70% and 18% respectively 15 years earlier. It should also be noted that these low-income rates are based on income before taxes and do not take into account tax credits and exemptions for age or the property tax reductions available to seniors in certain provinces. Thus, the actual level of hardship might be overstated to some extent.

Overall, the financial status of seniors has improved considerably in recent decades, even though many still have modest incomes that can make them vulnerable if unexpected expenses arise. The Old Age Security Program, the Guaranteed Income Supplement and the Canada/Quebec Pension Plan have certainly contributed to this improvement in economic status. Government transfer payments (1994 data) represent 55% of the overall income of seniors, compared to 47% in 1981. Women rely more heavily on government transfers, which constitute the sole source of income for 44% of elderly women; the same is true for only 22% of men in the same age group. Government programs have played and continue to play a determining role in ensuring the financial well-being of senior citizens.

This change is also attributable to the complementary nature of public and private income sources. In 1994, 19% of seniors' income came from employment-related private retirement plans, compared to only 12% in 1981. A small portion of seniors' income comes from registered retirement savings plans (4% of overall income), but these figures are likely to increase in the future, since a growing number of Canadians have RRSPs. Senior men currently benefit more than women from private pension plans, since there were proportionately fewer women belonging to those generations who worked all their lives and contributed as

much to pension plans. In fact, disparities in income distribution seem to be rooted initially in the realities of a segmented labour market which gave some, but not all, workers the opportunity to save for their retirement. Those who do not have private pensions and/or investment incomes, mostly women and people living alone, have the lowest average income level and are far more dependent on government transfers.

What can the seniors of tomorrow expect? There is every indication that today's adults will be better prepared financially for retirement. Nevertheless, some of them will still depend primarily on government pension plans. The progress achieved by women in labour market participation over the past 25 years will improve the financial situation of retired couples and should also enhance the financial status of retired women. However, the financial situation of retired women will undoubtedly remain less favourable than that of retired men because women are required to interrupt their careers in the work force more often due to family responsibilities, and tend to occupy lower-paying jobs in sectors where employment-related private pension plans are meagre or nonexistent.

The percentage of workers participating in employer-registered pension plans has remained relatively stable for the past 15 years at 44%, whereas the growing popularity of group RRSPs presages an increase in the number of workers covered by such plans. It is worrisome to note the large increase in unused RRSP contribution room, and the fact that only one in three workers with RRSP eligibility makes contributions each year. A substantial proportion of the unused contribution room is attributable to low-income individuals, many of whom may never have the means to contribute to an RRSP. Tax filers in their late 40s and 50s have the highest rate of RRSP participation and the highest average contribution level. The first members of the baby-boom generation have recently entered these optimum RRSP participation years; it remains to be seen whether this situation will give rise to a gradual exhaustion of accumulated RRSP contribution room.

Challenges

- Preserve the government pension plans, which are the sole guarantee of a minimum level of financial well-being for many present-day and future seniors.
- Immediately improve the economic situation of future seniors by combating the known causes of poverty and of financial dependence during retirement, namely, the polarization of the labour market, the professional ghettoization of women and unequal access to employment, and wage disparities between men and women for comparable work.
- Focus special attention on older workers excluded from the labour market who must draw upon their retirement savings to survive prolonged periods of unemployment.
- Improve data collection methods to measure every aspect of wealth and to combine these data on all members of a given household to get an accurate picture of the economic well-being of an individual. The well-being of individuals does not only depend on themselves but also that of the household to which they belong through the pooling of wealth.

Indicators of change

- Improvement in the financial well-being of retired women, particularly unattached women.
- Increase in knowledge regarding assets and the economic well-being of families.
- Higher percentage of workers participating in private retirement plans or making contributions to RRSPs or other private savings.
- Decreased percentage of seniors who are financially vulnerable.
- Greater parity in financial security between senior men and women.

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4.2 PUBLIC PENSION SYSTEM

Issues

In the past 50 years, Canada has established and progressively enriched a public retirement income system designed to provide a minimum subsistence level and to replace work-related earnings. These programs include the Old Age Security (OAS), Spouse's Allowance (SA), Guaranteed Income Supplement (GIS) and Canada Pension Plan (CPP) and Quebec Pension Plan (QPP), as well as the age and pension income federal tax credits. Although these programs have been generally successful in reducing the prevalence of poverty among seniors, there are inequities in these programs that have not been addressed.

Since the mid-1980s, successive federal governments have sought to reduce expenditures on public pensions, fearing that the pension system would fast become unsustainable in the current economic situation of high debt/deficit and low productivity. The public discourse, however, tended to pit seniors against younger generations rather than recognize that the real problems (and hence only real solution) lay in economic performance.

By limiting eligibility to spouses and widowed spouses of OAS/GIS beneficiaries from age 60 to 65 only, the SA discriminates against never-married and divorced/separated low-income women. Basing OAS and the age and pension income tax credits on individual rather than on family income leads to differences in overall benefits between couples who have two incomes and those who have one, by favouring the first group, even though their total income is the same. These inequities in the system have not been addressed satisfactorily.

Since 1989, there has been an income threshold above which OAS benefits are gradually reduced and which is only partially indexed to inflation. Because they are not fully protected from inflation, more and more Canadian seniors are becoming subject to OAS benefit reductions each year. By 2030, seniors with an income equivalent to $20,000 in 1989 dollars will have their OAS benefits gradually reduced.

In most Canadian communities, seniors who rely primarily or only on OAS/GIS live under the Statistics Canada's Low Income Cutoff (LICO). The cutoff determines who is doing less well than the average. The hardest hit are persons who are alone (i.e. who live alone or have no family relationship with the other members of the household) and whose OAS/GIS income reaches only 60% of the LICO for a large metropolitan area.

The CPP/QPP was amended in 1997 following extensive consultations with Canadians by federal and provincial governments. To ensure the Plans' solvency, greater equity between generations and continued public support, contribution rates are increasing over six years to 10%. Pension benefits are being reduced by basing them on the last five years of earnings instead of three. Although the benefit reduction is not large, it may hurt the

lower-income retirees with no private pension or significant retirement savings who depend most on CPP/QPP: many of these are women.

Challenges

- Address the persistent inequalities in the current public pension system that discriminate on the basis of marital status.
- Fully index the OAS income threshold to stop the insidious erosion of benefits.
- Increase public pension benefits to the lowest-income seniors by an amount that makes an appreciable difference in their quality of life.
- Inspire continued public confidence in, and support for, a public retirement income system which provides a minimum guarantee of financial security to seniors and which reduces disparities among Canadians in earnings and savings capacity.

Indicators of change

- Greater equity of the public pension system among married, widowed, single and divorced/separated seniors.
- Greater inflation protection of public pension benefits and of taxation thresholds for benefits.
- Reduction in the extent of poverty of seniors whose sole source of income is the public pension system.

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5. WORK AND TRANSITION TO RETIREMENT

5.1 OLDER WORKERS IN THE WORK FORCE

Issues

Over the past 20 years, there has been a steady downward trend in the labour force participation rate of older workers compared with that of all workers. This decline would have been much larger had it not been for the significant increase in women's participation. Participation of men 45 to 64 years old in the work force fell from 86% to 78% between 1976 and 1997, while the participation of women in the same age group rose from 41% to 58%.

The paths leading to retirement are as varied as the age at which individuals retire (from their early 50s to after age 65). Research shows that, although many of these workers leave the work force willingly, owing to pension plans and special incentive measures, some leave unwillingly as a result of lay-offs, extended periods of unemployment, health problems and deteriorating working conditions, or because pressure is brought to bear on them to make room for younger workers. Owing to the concentration of older workers in declining sectors of the economy, those workers are affected much more than others by closings and lay-offs. In addition, many older workers are excluded from the new information economy because they do not have the necessary level of education or because employers generally consider it less cost-effective to retrain older workers than to improve the skills of younger workers.

A number of conditions can also lead unions to negotiate early retirement. Early retirement can be seen as desirable in sectors with difficult working conditions or where the just-in-time system increases the production line speed so much that repeated micro-injuries and other problems become common.

As well, older workers need to recognize that they are responsible for investing in their own future by keeping their skills up-to-date and managing their own careers. The responsibility should be shared with unions and employers to establish mechanisms for providing and improving continuing education for workers of all ages. Many unemployed older workers are reluctant to undertake skills upgrading or retraining activities. Often, this is because of a lack of self-confidence due to few basic skills or a low level of education, and the perception that the effort is not worthwhile either for the employer or the employee: in the short term, too much effort would be required to acquire new skills or improve old ones. This can be especially difficult for women who enter the work force late or who return to it after an extended absence.

In the Public Service, government practices in the management of the aging work force are usually limited to offering early retirement packages to older workers. The main goal is to reduce the size of the Public Service; there are no strategies for keeping older public servants on the job. The same practices also exist in the private sector. In terms of social policies, government has so far taken a passive approach to dealing with the exclusion of older workers from the labour force. The government intervenes only after layoffs occur and on an ad hoc basis, and takes responsibility,

after a fashion, for older laid-off workers until they reach retirement age, rather than really helping them find another job. Job search and counselling services designed for the general public are not very interested in older workers and are not effective in finding them a "real" job.

There is also tacit pressure for early retirement. Governments have modified their income security plans in a way that accelerates older workers' exit from the labour force: the Quebec Pension Plan and the Canada Pension Plan allow early retirement from age 60; the eligibility criteria for disability benefits have been eased, and social assistance reforms have been passed that exempt almost all beneficiaries aged 55 and over from employability measures.

The next generation of retirees will be much larger than the next generation of young workers entering the labour market. Moreover, fewer people will be available for work, following the entry into the labour force of the last of the baby boomers in the late 1980s. The economy may experience a labour shortage. As well, the rate of increase in the number of women under 45 in the work force is expected to fall gradually once the "maximum" participation rate is reached. Once these two sources of labour become less plentiful, the participation of older workers in the labour force will likely become the major factor influencing its growth and productivity. Older workers aged 45 and over represent an important labour pool for the future growth of the economy, accounting for nearly 33% of the labour force by 2000 and 40% by 2010.

Therefore, measures should be taken to ensure that older workers are available and motivated to work, and that they have the necessary skills to keep the economy productive and growing. Methods should be found to keep them in the active population as long as they are able and prepared to stay. In a society in which the active population is aging, employment policies should reflect the fact that pre- and mid-employment training is important for everyone, including older workers, and that wasting their contribution is a negative way of managing the Canadian economy.

Challenges

- When there are lay-offs, ensure that all workers, regardless of their age, get the necessary career counselling, that they are able to participate in job creation and training programs, and that they are provided with sufficient financial assistance during the transitional period between the lay-off and their return to work.
- Increase alternative and flexible work arrangements such as part-time work, gradual retirement, working at home, access to education and retraining, or by reducing stressful responsibilities or assigning fewer arduous physical tasks.
- Labour policies should take into account the family responsibilities that employees have with respect to all members of their family, including caring for a dependent senior adult.
- Ensure that workers of all ages have access to career counselling services and that they are provided with lateral or vertical advancement opportunities during their career, in order to maintain an atmosphere of growth and development in the workplace.

- The federal and provincial governments should harmonize their social assistance programs and introduce the necessary reforms to make it financially advantageous for older workers who so wish to re-enter the work force.
- Mandatory retirement at age 65 should be abolished in those provinces where it still exists.

Indicators of change

- Reduction in the extended period of unemployment among persons 45 years of age and over.
- Reduction in the proportion of retirees who retire *involuntarily*.
- Increase in participation rate of persons 45 years of age and over in the labour force.

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5.2 WORK-TO-RETIREMENT TRANSITION

Issues

Over the past quarter century, the median retirement age for all workers has fallen from 64.9 in 1976 to 62.3 in 1995. Public sector workers posted the largest decrease in median retirement age during this period, from 64.6 to 59.8, followed by private sector workers, for whom the median age has fallen by two years, to 63.1 today. Many of these workers left the labour force by choice, enticed by interesting and promising options connected with early retirement. However, some retired prematurely and/or involuntarily, due to a lack of better alternatives. This was following an extended period of unemployment or periods of re-entry into the labour market in jobs that did not use their skills and that were often not as well protected as those they previously occupied. The people in the latter category are a group that is vulnerable to poverty, anxiety and deteriorating health at a stage in their life that should have been devoted to accumulating wealth and preparing for retirement. The paths to retirement, therefore, vary greatly and have an impact on the long-term well-being of new retirees and their families.

Those who adjust well to retirement are generally in good health, have sufficient income and a satisfactory family life, participate in community activities or have interests outside work, and consider retirement a positive and normal stage in life.

Studies indicate that success in retirement, as in any other important stage in life, requires some preparation. The preparations should be made early, should not be limited to financial considerations and should make workers of all ages more aware of the importance of having sources of support and involvement outside the work place.

The transition to retirement is often associated with permanent withdrawal from the work force and a move to a life devoted exclusively to leisure pursuits. However, increased life expectancy, better health and earlier retirement are helping change the way people perceive retirement and making it less static. Today, some retirees opt to return to school or to do volunteer work; others accept part-time paid employment, out of interest or need. For many, the period of euphoria immediately following retirement often changes into a search for new meaning in life. Paid or volunteer work provides an often unrecognized source of feelings of self-worth.

In the future, retirement could take on another face. Demographic and economic changes may lead skilled, qualified workers to remain in the labour market longer. Ideally, people of all ages should be able to arrange their lives in a more flexible way, take development or transition leave, and enjoy leisure activities throughout their lives.

Challenges

- Make Canadians of all ages aware of the importance of having activities, not all connected with paid work, that give them feelings of self-worth and usefulness. They will then find it easier to adjust to loss of or separation from employment when they retire.

- Ensure that all workers have access to pre-retirement courses as an employee benefit. These courses must not look only at financial considerations; they must cover all aspects of life, including the impact of retirement on married life, housing, diet, time management, and so on.
- Provide training and educational activities for all older workers, in order that they may retain and improve their skills and motivation, and successfully manage their work life and retirement.

Indicators of change

- Expanded range of social roles played by persons over the age of 65, with and without remuneration.

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5.3 VOLUNTEER WORK AND SENIORS' CONTRIBUTION

Issues

Seniors contribute significantly as volunteers and charitable donors. According to the 1997 National Survey of Giving, Volunteering and Participating (NSGVP), the percentage of Canadians who make financial donations to charitable and non-profit organizations increases with age. Close to 60% of Canadians in the 15-24 age group were donors; this increased to 78% for those between the ages of 25-34, was relatively stable at 83% for those between the ages of 35-64 and dropped slightly to 80% for those aged 65 and over. The average value of donations rises with age, from $79 for those aged 15 to 24, to $328 for those age 65 and over. The volunteerism participation rate is 23% in the over 65 age group (31% in the 15 and over age group), and the average number of hours volunteered annually by this age group is highest, at 202 hours.

In general, seniors who volunteer have higher levels of formal education, income and self-assessed health than non-volunteers, and are more likely to be women and to have volunteered when younger. The kinds of informal assistance provided by seniors to others differs by gender, with men most likely to provide help with transportation, and women most likely to provide emotional support or everyday care (help with dressing, meal preparation, etc.).

There is an ever-increasing quantity of reliable statistics on volunteerism which underscores the economic contribution of volunteers. Studies have shown that the market value of voluntary assistance to others by individuals over 55 is over $10 billion. If volunteers did not provide such assistance, either the community standard of living would suffer, or the government and the private sector would have to supply the missing assistance. Attributing a monetary value to volunteerism shows the importance of supporting this kind of social commitment. Many people say that some of the expenses related to volunteerism should be covered and that steps should be taken to ensure that leadership and coordination are provided within the organizations.

With the advent of new cohorts of seniors with different characteristics from their predecessors, the volunteer reserve is changing and their motivations might be different. Some will be prepared to assist seniors with disabilities in their homes while others will see volunteerism as an opportunity to meet active people outside their homes; still others will refuse to make long-term commitments in order to remain free to travel. One factor is important, however: to reach seniors and involve them in volunteerism, it is important to recognize the value of the commitment they are making.

Challenges

- Examine in greater detail and publicize the contribution already being made by senior donors and volunteers.
- Maximize opportunities for older workers and seniors to give themselves and society the benefit of their talents and social commitment. For example, employers could facilitate the

volunteer and community work of their employees (particularly pre-retirement employees), thus smoothing the transition to retirement.

- Provide financial support to community organizations that promote seniors' social involvement.
- Better understand and eliminate the obstacles preventing or limiting social involvement by seniors.
- Provide training and support to volunteers in order to recognize, value and encourage their participation. Reimbursement of volunteers' indirect expenses is one way of recognizing their participation.

Indicators of change

- Increase in corporate and public funding committed to support the voluntary sector.
- Increase in the percentage of retired persons who volunteer.

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5.4 OLDER ADULT EDUCATION

Issues

In the information society of today and tomorrow, education is the key to developing the human resource potential of seniors. Education in the third age (i.e. 50+) encompasses a wide variety of planned learning activities: traditional and non-traditional, formal and informal, collective and individual. Whether learning is directed toward acquiring new skills, continuing a lifelong interest, or developing one's social relationships, it is a means for better understanding the complexities of today's world and meeting the challenges of aging. The growth of older adult educational programs across North America has suffered from the general view that education is a luxury for the elite few. While participation in many college or university-based educational programs has so far drawn mainly seniors who already have post-secondary education, educational opportunities of all kinds, offered by educational and cultural institutions and by other community resources, must be available for people of all ages, and most particularly for seniors who also have not been well served by education in their earlier lives.

Recent research suggests that the mind can continue to grow and develop to the end of life—if it is stimulated and challenged. It has been said that education is as critical to the quality of life of seniors as income security or adequate housing. Many who work in older adult education know from experience that education has a powerful impact on health—to be involved in learning is to be vital and active. It is apparent that intergenerational education has social value. Such benefits include overcoming ageist stereotypes; providing opportunities for exchange of services; building intergenerational bonds; and developing new understanding of a wide range of historical topics and social issues. Other effects among the young include greater tolerance and an appreciation of what it means to grow old. However, research documenting the benefits of older adult education on seniors' health, productivity and quality of life and the benefits of intergenerational activities has not received adequate support.

Older adult education in North America has focused on three pillars: leadership; lifelong learning; and service. This framework is useful for considering the past and future of the field in Canada.

Leadership is important in all spheres of human activity—and no less so in the development and maintenance of services to seniors. Seniors' groups and organizations depend on senior volunteer leadership. For 25 years, the federal government's New Horizons Program supported innovative learning opportunities for seniors in communities across Canada. Continued financial and administrative support facilitated the subsequent evolution of seniors' centres and the emergence of seniors as leaders in their centres and in the broader community. The need for effective senior

leadership remains, and will grow. Yet, since the termination of New Horizons, few opportunities for developing organizational leadership or delivering leadership training are available. The provinces and communities were unable to continue funding these community programs once federal government support ended.

In this age of information and technology, lifelong learning has become a widely accepted concept. The *NACA Position on Lifelong Learning* suggested how education can serve seniors' needs for coping, self-expression, achieving personal and social goals and finding meaning in life. Yet, during the past decade, cutbacks in federal and provincial funding for health and education have resulted in a reduction in the availability of courses to seniors and a decline in the enrolment of persons 60+ in universities and colleges. Courses for seniors are increasingly non-credit, and subsidized by fees charged to participants and funds raised by seniors themselves.

Seniors' centres have increased their emphasis on activities of an educational nature, particularly in urban centres. To attract their members to these activities—many of whom do not have a positive attitude toward "education"—the centres called them "mental fitness" programs. Seniors' centres are ideal public sites for adult education and deserve greater public recognition and financial support.

The last pillar of older adult education is service. Peer counselling, wellness, support groups and outreach programs all provide opportunities for seniors to learn to create new roles for themselves. These programs fill a gap in service provision to seniors, providing vital connections to health care and social services, notably for isolated seniors. During the 1980s, more than 20% of the seniors' projects funded by the federal government were service oriented. Since the termination of New Horizons and of the Seniors Independence Program, many of these programs have not survived. In the future, the revitalization of programs designed to train and support senior volunteers will be necessary to complement and sustain formal health and social services.

Challenges

- Provide opportunities in the community to train seniors as leaders, giving them the skills and resources to assume and maintain leadership roles.
- Support seniors' centres to promote older adult learning and community leadership.
- Increase support for research on the benefits of older adult education on health, well-being and social engagement.
- Increase public support for community-based learning opportunities, not only in institutions of higher learning, but also in centres that reach out to seniors with low literacy, seniors with limited knowledge of English or French, and seniors at risk for health or social problems.

Indicators of change

- Greater participation of seniors with both high and low levels of educational attainment in learning activities.
- Greater allocation of public resources for community-based learning programs.

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6. INTERGENERATIONAL ISSUES

Issues

As life expectancy increases and the number of retired persons rises, some people are wondering whether the mechanisms of intergenerational solidarity will break down, given the growing imbalance between the size of the group receiving the benefits and the size of the group assuming the costs. At the same time, some people claim that seniors are using more than their share of society's meagre resources, which should be allocated to other age groups (poor children and their families). These issues relate in particular to the pensions and health sectors. To ensure that public debate reflects all the nuances of the issues, certain points for reflection should be taken into consideration:

- public support strengthens private support;
- increased public spending will not be catastrophic;
- the potential of the oldest members of society is not fully used; and
- seniors contribute to the funding of public spending.

Public support strengthens private support

First of all, it is important that a distinction be drawn between two types of intergenerational exchanges. On the one hand, there are exchanges of help and services—sometimes money—within families and between individuals, which we will classify as "private support." On the other hand, there are intergenerational exchanges that take place through social protection policies, which we will classify as "public support." We understand a little better today the interdependence of these two types of intergenerational exchanges: for families in which the children and parents have limited resources, withdrawal of public assistance creates an accumulation of burdens and problems that can lead to a breakdown of private support.

Government thus plays a central role in maintaining and strengthening exchanges between generations. For example, when society assumes collective responsibility for providing part of the care of its seniors, through health care, extended care or pension payments, the children and families of seniors are relieved of a burden that would be too heavy for them to bear alone. Some studies have shown that, contrary to popular belief, public support does not lead people to be less committed to their families; rather, it encourages intergenerational family support. More than complementarity, the result is a true synergistic effect.

The statistics on family composition show that seniors have and will continue to have for some time a significant family entourage, a potential source of support in case of need. The proportion of seniors living with a spouse is also increasing. However, future cohorts of seniors will include a larger percentage of individuals struggling with the long-term consequences of divorce, single parenthood, remarriage and blended families. It is still too soon to measure the impact that these changes in the family will have on family self-help, but decision makers must remember that any reduction of services to the population must take into account the potential of family self-help.

Increased public spending will not be catastrophic

Projected government spending in the pensions and health sectors will have to increase significantly as the population ages if we want to maintain a quality of life comparable to that of today. However, although some public expenditures are for age groups that are often termed "dependent" (young people, seniors), others are for the entire population (national defense, fire departments) or the 20 to 64 age group (employment insurance, correctional services). Examination of the changes in overall public spending over the next few decades shows that total costs will increase at the same rate as the total population. Per capita costs could therefore remain stable. The main challenge will be to determine how to modify and transfer budgets to accommodate the increase in demand in some sectors and the decrease in demand in others.

The potential of the oldest members of society is not fully used

Society today has made few adjustments with a view to tapping the potential of its oldest members. Business and government practices with respect to managing the aging labour force are usually limited to providing early retirement programs for older workers. In addition, seniors who wish to remain in the labour force are prevented from doing so—for example, by mandatory retirement policies based on an arbitrary age limit, rather than on an assessment of competencies and of ability to contribute to society. Socio-economic factors such as age upon retirement and the maintenance of seniors in the labour force can have a considerable impact on the level of demographic dependence of young people and seniors on persons of working age. Action is therefore possible. Ways must be found to ensure that these people remain in the labour force as long as they wish and are able to do so, to maintain a productive and flourishing economy.

Seniors contribute to the funding of public spending

The contribution that seniors make to the funding of social spending is often disregarded. Seniors do more than receive. They also contribute to the funding of public spending in various ways: through personal income tax, consumer taxes, participation in the labour market, and participation in business and industrial concerns that pay corporate income tax. It has been calculated that the average contribution of a senior to the revenues of the federal and provincial governments is more than half

that of a person 20 years of age or older. Finally, the increase in social security (payroll) taxes could be in part offset by private transfers (inheritance) of wealth from one generation to another.

Challenges

- Increase knowledge regarding the dynamics of intergenerational transfers within families and regarding the role of public support in aiding and strengthening private support.
- Increase the number of community initiatives and put in place new infrastructures (e.g. volunteer services provided by seniors in schools and meals-on-wheels services provided by young people) to bring closer together generations that may have seen their traditional ties eroded as a result of far-reaching changes in family structure and in the workplace.
- In the context of the public discussion of these issues, remind people of the contribution that seniors make to the funding of the public system.
- Fund research, documentation and dissemination of knowledge in this area to remind the public that mutual support between generations is one of the determining factors for the health and well-being of each of us.

Indicators of change

- Increased public recognition of the contribution of seniors to society and families and of the importance of intergenerational solidarity.
- Reduction of ageism in public discourse.
- More policy focus on inequalities within generations rather than between generations.

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