Senior Citizens' Secretariat
Newsletter

VOLUME 110 DECEMBER 2004

Message from the Executive Director

As the Holiday Season approaches, we look forward to spending more time with our family, friends and neighbours in our own community. I was pleased to have had the opportunity to visit many of your communities over the past two months. Through our Task Force on Aging initiative, we completed thirty-four public consultation meetings across Nova Scotia between Oct. 25 and Dec. 3.

It has been some time since I have been able to travel so extensively throughout the Province and I enjoyed renewing old friendships and reconnecting with so many seniors, dedicated volunteers and professionals who work in the field of aging.

We had lively, informative meetings with an average of about 20 people at each. I appreciate the efforts that were made to come out for the meetings. If you were not able to attend, you can still submit your comments to us by December 31st. You can also read more about the Task Force on Aging consultations in my article on page 3.

In other Secretariat news, we are pleased to have recently hired Barb Baker as a consultant to our Elder Abuse Prevention Strategy. Barb is working with Secretariat staff, a provincial committee and working groups, and partners/stakeholders on developing and implementing a workplan to take action on the recommendations of the Strategy.

And finally, stay tuned for our 16th edition of the *Programs for Seniors* booklet to be released in March 2005. We are always looking for cover photos for our program and other publications and welcome your submissions.

On behalf of the staff of the Senior Citizens' Secretariat, A Very Happy Holiday Season and our warmest wishes for a Healthy and Prosperous 2005.

Valerie White

Valerie White making a presentation at the Task Force on Aging Consultations as Heather Praught looks on.

What's inside ...

Secretariat Newsletter

The Secretariat Newsletter is published four times a year by the Senior Citizens' Secretariat and distributed free of charge. We welcome letters, articles, and items of interest from you. Please include your name, address, and telephone number on all correspondence.

The Senior Citizens' Secretariat was established in 1980 to facilitate the planning and development of services and programs for seniors by coordinating plans, policies, and programs presented by the departments of the provincial government. The Secretariat serves as a one-door entry to government for seniors, seniors' groups, and other provincial bodies concerned with aging issues. The Secretariat develops plans, policies, and programs in partnership with other levels of government and agencies responsible for seniors.

The Secretariat's office is located at 1740 Granville Street, 4th floor, P.O. Box 2065, Halifax, NS B3J 2Z1. Tel (902) 424-0065; fax (902) 424-0561; toll-free 1-800-670-0065. E-mail scs@gov.ns.ca Website www.gov.ns.ca/scs

Task Force Aging Update

by Valerie White

The Task Force on Aging public consultation process involved six weeks on the road, logged more than 5,600 kilometres, and gave three Secretariat staff members the distinct pleasure of meeting more than 700 people. If the experience taught us one thing above all the others, it is that solutions for an aging population will be found in Nova Scotia's strong sense of community.

On Oct. 20, the Task Force on Aging released the *Discussion Paper for Positive Aging in Nova Scotia* to get feedback on the proposed vision, principles, nine positive aging goals, and the actions we need to take as a society to ensure Nova Scotia is able to meet the needs of seniors and provide a positive aging experience. At 34 public consultation meetings held between October 25 and December 3, we asked Nova Scotians to share their concerns, recommend priority actions, and help shape the future of our province. And they delivered.

At the heart of all our discussions was the shared goal of ensuring that Nova Scotia's seniors are able to live independently for as long as possible and are able to contribute to our society. In order to achieve this goal, we heard that improved transportation—especially in rural Nova Scotia—is needed. We also heard that financial security at retirement is vital to supporting healthy, active lifestyles and the availability of affordable housing options is critical to positive aging. More supports for caregivers are needed, and professionals in the fields of physio and occupational therapy spoke about the far reaching benefits of ensuring seniors are able to remain mobile and active as well as the need to focus on falls prevention. We heard many times about how difficult it is for community groups to attract new volunteers. Fewer people are carrying the burden of this important work, which is seriously challenging community-based services at a time when demands are growing.

Although these were some of the common threads that emerged across the province, we were consistently reminded that our communities are as diverse as our people. Every meeting provided unique insights and highlighted individual needs.

In several places, we saw firsthand the impact better communication between organizations can have on the effectiveness of programs. These experiences emphasized the need to bring community groups together to build partnerships, share resources, prevent duplication, fill gaps in services, and better inform seniors about the services available to them.

By far, the most rewarding part of our journey around the province was meeting so many wonderful people who are doing so much positive work on behalf of older Nova Scotians. We are grateful they took the time out from busy lives to participate in Task Force meetings. Their dedication to their communities and their commitment to meeting the needs of seniors now and in the future is greatly appreciated.

Special thanks to Royal Canadian Legion branches across the province, which provided meeting spaces free of charge. Thanks also to our community ambassadors who helped promote the meetings and graciously welcomed us to their community.

Nova Scotia's strong sense of community is a powerful force. I firmly believe that it will help us overcome the challenges by seizing the opportunities that come with an aging population.

In January 2005, the Secretariat will organize focus group meetings on specific topics, such as transportation, housing and volunteerism. *The final Strategy for Positive Aging in Nova Scotia* will be submitted to Cabinet in March 2005, followed by a detailed action plan in the fall. But before any of this is done, we need to hear from as many people as possible. If you haven't done so already, please contact our office (**1-800-670-0065** toll free or **424-0065** in the Halifax area) to get a copy of the Discussion Paper. You'll find a questionnaire inside, which can be mailed or faxed to our office by December 31, or you can fill it out online at **ww.gov.ns.ca/scs**.

There is still time for you to share your own insights and experiences, and to help shape the future as we work toward building a society that promotes the well-being and contributions of older Nova Scotians in all aspects of life.

ACTIVE LIVING

Canada Senior Games

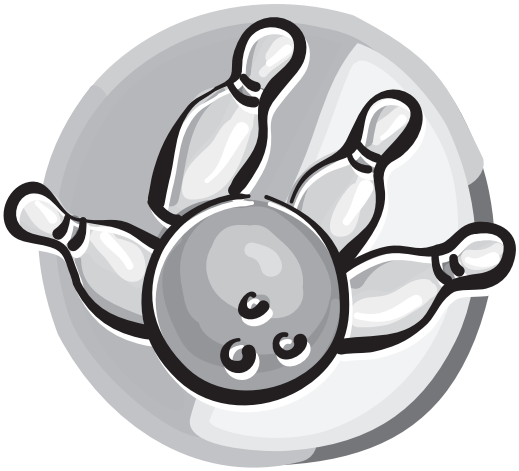
The Canada Senior Games is a wonderful opportunity for older adults 55+ from across our nation to unite for a common goal of healthy aging, active living, friendly competition and social camaraderie. These Games were founded by the Canadian Senior Games Association, and is a National multi-sport/activity Event that includes a combination of up to 20 physical and mentally challenging activities, from swimming, to track and field to cribbage and much in between!

The games are hosted every two years. Each Territory and Province strives to have its own set of games. Those who qualify move on to the National Games. Even with this required qualification, the range of activities offered lends itself to be very inclusive to all older adults in Canada.

For more information contact:

www.csga.info or **info@csga.info**

In Nova Scotia contact:
Peter Nordland
PO Box 235, Cornwallis, NS B0S 1H0;
Tel: (902) 638-8009
E-mail: nordland@ns.sympatico.ca



Nova Scotia 55+ Senior Games

will be held Sept 28 to October 1, 2005 at Cornwallis Park, Halifax

Activities to include: 8-Ball, 45's, Bowling (5-Pin and Candlepin), Bridge (Contract and Duplicate), Cribbage, Curling, Darts, Golf, Hockey, Horseshoes, Lawn Bowling, Painting, Photography, Quilting, Scrabble, Slo-Pitch, Swimming, Tennis, Track and Field, and Whist.

For further information, contact one of the following:

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Tel: (902) 638-8009
E-mail: nordland@ns.sympatico.ca

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Tel: (902) 895-5224
E-mail: tyra@eastlink.ca

Ken Brown, Member:
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E-mail: nsfsna@allstream.net

Ski Atlantic Seniors' Club

In its fifteenth year of operation, the Ski Atlantic Seniors' Club boasts approximately 500 members, and utilizes the various Maritime ski slopes: Martock, Wentworth, Ben Eoin, Poley, and Crabbe. The club hosts a number of special events, with the 2005 Eastern Townships Adventure scheduled for February 6–12. For further information contact Shirley Rogers at **(902) 893-7401** or by email at **srogers@tru.eastlink.ca**.

In order to receive a ski pass you must be 65 years of age or older, or retired from regular employment and are 55 years of age or over. This pass entitles the member to ski participating ski areas in Nova Scotia and New Brunswick. The $150 pass fee includes HST, plus club dues of $15 (total of $165).

To become a member of the club contact:
Mary Kitley, Registrar
Ski Atlantic Seniors' Club (SASC)
14 - 4 Westwood Boulevard, Suite 361,
Upper Tantallon, NS B3Z 1 H3
Tel: (902) 462-0713.

For information on Club activities contact:
Faye Tabor: (902) 835-5195
Bob Webb: (902) 897-4679.

Sneakered Seniors are Safest

Most of us know of at least one senior citizen who has taken a tumble. These falls can result not only in serious injuries but death. Does it make a difference what shoes seniors wear?

Study: More than 1,000 seniors (ages 65 and older) were followed for two years. About a third of the group fell at least once during this time period. Wearing shoes other than sneakers increased the risk of falling. Going barefoot or in stocking-feet increased the risk of falls even more. Surprisingly, most falls did not occur in the bathroom but while walking outdoors.

Comment: We keep reasonably up to date on the latest shoe styles. It is our impression that while the colors, designs and models for most athletic shoes are constantly being changed and updated, most of the walking and therapeutic shoes aimed at seniors are either white, brown or black and not very fashionable. Given the fact that the number of older people in our society is increasing all the time, we would think that this would be a major window of opportunity for shoe designers.

Barbara K. Hecht, Ph.D., Frederick Hecht, M.D.
Medical Editors, ***MedicineNet.com***

"There is no pleasure in having nothing to do. The fun is in having lots to do and not doing it."

- Mary Wilson Little

Italy Art and Soul

17 Days April 5 – 21, 2005
Venice – Florence – Rome

To explore, with Adrian Hoffman, a special kind of Italy and to learn more about music and art in Italy you may want to check out the Italy Art and Soul tour. The trip includes San Marco Doge's Palace, ancient Rome, Vatican Museums, a Papal audience, plus much more. A trip of a lifetime just a phone call away!

For itinerary information contact:

Wanda R. Graham
Tel: (902) 868-2556
E-mail: wandargraham@hfx.eastlink.ca.

To book contact:

Michelle MacKenzie
IH Mathers Tours and Travel Ltd.

Tel: (902) 429-5680 or
E-mail: michelle@ihmatherstoursandtravel.com

CAREGIVING

Caregiving: Whose Responsibility?

Marjorie Silverman, Caregivers Support Centre, M.A., CLSE René-Cassin/ISGQ;

Ignace Olazabal, PhD., Researcher, CLSE René-Cassin/ISGQ

In the last ten years in Canada there have been encouraging advancements in caregiving research, advocacy, sensitization, and political awareness. We now know about the tasks informal caregivers perform, the challenges they face, and the physical, psychological and financial stress they often experience[1]. We acknowledge that caregivers contribute an invaluable service to our communities and to the health care system, and we recognize that they themselves require both instrumental and emotional support. Caregiving issues are finally starting to make their way into the political arena,

as politicians are realizing the urgency of the challenges presented by our aging population.

Despite the "coming out" of caregiving issues, the fundamental question of who should assume the responsibility for care continues not only to present challenges but to shape the daily lives of all family caregivers, community members, and professionals in the health care system. Should care be the responsibility of governments, families, communities, or hired professionals? Embedded in our answers to this question are often undeclared assumptions that impact on the structure of our health care system, as well as the expectations placed upon family caregivers.

On June 18, 2004, the Caregiver Support Centre of the CLSC René-Cassin/Institute of Social Gerontology of Quebec hosted a Visioning Day on the subject of informal care. The goal of the day was to bring together researchers, practitioners and caregivers to share their thoughts on the future of caregiving research and practice[2]. The participants spent the afternoon engaged in a debate about he question of responsibility for care. The debate, which included a lively skit led by Nancy Guberman and Jean-Pierre Lavoie, highlighted the gravity of the caregiving problematic: What do people do when their lives are drastically altered and they require care that the public system does not provide? Should governments provide more or should it be the responsibility of families to care for their own? At what point should the community become involved? None of the professionals in the room had an answer. Yet further reflection about value systems revealed that, although no one had an answer, everyone had an opinion.

Most people would probably agree that responsibility for care should be shared, yet very few can articulate how this should be divided. It became clear to the participants at the Visioning Day that despite their inability to devise a breakdown of responsibilities, their value systems dictated certain assumptions, for example that families should take on more or less responsibility. Similar assumptions and opinions are found throughout the health care system, to the point of impacting on policy[3]. If CLSCs offer clients only one bath per week, implicit in that offering is the idea is that families should be absorbing more responsibility for care. No one would disagree that families should have choices, as not everyone wants to, or is capable of, being a caregiver. Yet do families really have viable choices when they are offered so few reasonable options? If a caregiver cannot afford to pay for private help, then who will provide bathing assistance the rest of the week? The concept of choice becomes ethically questionable when the options to choose between are unreasonable, or when choosing not to provide care is often viewed negatively. Lack of choice forces caregivers to confront serious ethical dilemmas.

The redefinition of responsibility for care is placing increasing emphasis on the community, especially given that the Canadian and Quebec governments have explicitly expressed a desire to transfer part of the responsibility for care onto communities.[4] The involvement of the community in caring for those with loss of autonomy is an appealing concept, yet it is difficult to articulate or pinpoint what "community" really means. For some, community means religiously affiliated organizations or ethnic groups, whereas for others it means non-profit organizations, or the neighbour down the street. The concept of community is diffuse and open to interpretation[5], even though the idea of collectively sharing responsibility for those in need is a common value. The fact that Canada does not have the extensive social and community network found in countries such as Denmark[6] indicates that although the government wishes to transfer the responsibility for care onto communities, Canada's community structure may not be strong enough to handle the weight of responsibility. Denmark, whose policies prioritize care for older adults through prevention programs, active regional councils, and networks of support to combat isolation, emphasize the well-aging of older adults as a national concern. Prevention programs that aim to maintain the autonomy of seniors by combating physical and cognitive deterioration have cut in half the number of seniors living in residences.

Considering the fact that in Quebec, between 75 and 80% of all care is provided by families[7], it is clear to what point government-provided care (through CLSCs or long-term care facilities) is limited. It is thus important to reflect seriously

on the question of community care, as it has enormous potential to benefit families, and can constitute an exciting compliment to government-provided care. This reflection is ongoing and must involve not only policy makers and practitioners, but families and caregivers. After all, as Margaret MacAdam says, "Home Care: It's Time for a Canadian Model"[8].

1 Orzeck, P., N. Guberman, and L. Barylak (2001). *Responding Creatively to the Needs of Caregivers: A resource for health care professionals*. Montreal, Éditions Saint-Martin.

2 We would like to thank L. Barylak. S. Callender and all the members of the panel.

3 Lavoie, J-P, N. Guberman, M-E Montejo, S. Lauzon et J. Pepin (2003). *Problématisations et pratiques des intervenantes des services à domicile auprès des aidantes familiales*. Quelques paradoxes, Gérontologie et Société, no. 104, p.195-212.

4 Hollander, M.J. (2001). A Comparative Cost Analysis of Home Care Services. Final Report, Ottawa, Health Canada.

5 Martin, J - CO (1997). *Les personnes âgées, la famille et les autres, ou la communauté locale comme milieu de vie*. Lien social et Politiques RIAC, 38, Automne, p. 159-164.

6 Gyldén, A. (2004). *Au royaume des vieux*. L'Actualité, janvier.

7 Clément, S., et Lavoie, J-P. (2002). *L'aide aux personnes âgées fragilisées en France et au Quebéc - la question de la part des families*. Santé, Sociéré et Solidariré. 2, p. 93-102.

8 MacAdam, M. (2000). *Home Care: It's Time for a Canadian Model*, Health Care Papers. 1 (4), Fall.

Source: Vital Aging
Vol. 10, No. 3, October 2004

Looking after seniors: Who does what for whom?

by Susan Stobert and Kelly Cranswick

Surveys show the continuing willingness of Canadians to assist their older family and friends who need help because of illness or frailty. However; the growing size of the senior population, and particularly the rapidly increasing number of those in their eighties and nineties, raises the question of families' and volunteers' ability to provide the care needed to maintain a senior population independent in their own homes.

Recognizing the challenge of caring for seniors with long-term health problems, governments are searching for ways to support those Canadians who juggle many demands in order to provide care to their loved ones. It is necessary to establish who provides care to our aging population in order to better understand the consequences of caregiving and how best to assist caregivers. And the findings are important: for example, we often think of seniors as the receivers of care, but in fact older Canadians are also actively involved in caregiving.

This article will examine middle-aged (aged 45 to 64) and older (aged 65 and over) caregivers separately because the issues involved are quite different for each group. Generally speaking, the younger caregivers are working, in good health, have children of their own, and are providing care to someone who is older than themselves. As such, the psychological as well as practical dimensions of the relationship are quite different than those of a caregiving relationship between contemporaries.

Most middle-aged caregivers are looking after their parents

Over 1.7 million Canadian adults aged 45 to 64–16% of this age group—are providing informal care to almost 2.3 million seniors with a long-term disability or physical limitation. Most are looking after their own parents (67%) and their spouse's parents (24%). Many (24%) are providing help to close friends and neighbours.[1]

Although these middle-aged caregivers are just as likely to be men as women, the women dedicate almost twice as much time to their tasks 29.6 hours per month, compared with 16.1 hours for men. Working outside the home does not

significantly reduce the amount of time middle-aged people spend providing care; employed women still spend 26.4 hours a month and employed men 14.5 hours.[2]

One of the main reasons for the male-female disparity in care-hours is due to the nature of the tasks women are performing. They have more often adopted responsibility for keeping the household running smoothly; that is, they are doing housekeeping and helping with personal care. While men also help with these kinds of activities, they devote the majority of their time to tasks like household maintenance and transportation. In other words, the care giving labour is divided along traditional gender lines, which may reflect the providers' level of comfort performing tasks that mirror their areas of competence in their own homes.

Less than one in five of these care providers (17%, or 305,000 of more than 1.7 million) reported that they received help themselves if they needed a break from their responsibilities. Since most were taking care of their parents or parents-in-law, the lion's share of the extra assistance (82%) came from inside the family—a sibling, spouse or child. However, 16% of respondents relied on paid help (either private or government) for back-up when they needed a respite.

Only a small minority of care providers describe their lives as very stressful: 13%, the same as their counterparts with no responsibilities to a senior. The proportion who believed that life was somewhat stressful was just about the same as well: 49% versus 46% of other 45 to 64 year-olds.

Over one third (34%) were also very satisfied with their lives in general, a slightly higher rate than that recorded by middle-aged Canadians who provided no informal care to seniors with long-term health problems. This may be linked to feeling that they control all of the decisions affecting their day-to-day lives (25%). Social science researchers have shown that "mastery" is an important factor in contributing to a person's positive outlook on life.

Although they seem to be coping quite well with their responsibilities, caregivers really want some help themselves. When they were asked to identify the most useful thing to allow them to continue providing help, the most common answer (51% of care providers aged 45 to 64) was "occasional relief or sharing of responsibilities." Given that less than one fifth of them are getting this kind of help now, this response seems quite heartfelt. Other types of help, such as information to improve their skills or about the nature of long-term illnesses, more flexible work arrangements and financial compensation, were also suggested by a substantial proportion of caregivers.

Most senior caregivers are looking after their spouses, friends and neighbours

Over one in 12 Canadian seniors (321,000) is looking after at least one of their contemporaries whose day-to-day activities are restricted by long-term disabilities or physical limitations. They are most often providing care to a spouse (25%), close friend (33%) or neighbour (19%). The majority of them are women (59%), as one would expect of a population in which women outnumber men.

Senior women devote more time to care giving activities than their male counterparts—32.9 versus 20.9 hours per month—a gap greater than that between middle-aged caregivers. Being retired, men in this age group are now able to dedicate more time to these efforts than when they were working. They also spend a larger proportion of their caregiving hours on indoor tasks, perhaps because they are less vigorous than before, but women still dedicate most of their time to household tasks and personal care.

Few of these senior caregivers can rely on getting help if they need a break. Only 18% said someone else could take over their responsibilities to the care receiver should they themselves need, or want, some time off. For those who could call on someone else to relieve them, the help most often came from their own children, formal sources of help, or other family.

Body, mind, and soul

"Theories: What people have about raising children until they actually have childeren."

- Joe Heuer

Their lifestyle seems no more stressful than that of seniors who are not providing informal care. Only one third (34%) described their lives as very or somewhat stressful, and one third (32%) said they were very satisfied with their life in general, rates that are effectively no different than those of seniors with no care-providing responsibilities. Almost half (46%) reported that they felt they controlled all the decisions that affect their daily activities. This rate is much higher than that for middle-aged caregivers, and may indicate that seniors were more often living in circumstances that obliged them to take decisions on their own.

The rewards and demands of caregiving

It is well-documented that care giving can provide benefits not only for the receiver but also for those providing care. Asked about the intrinsic rewards associated with their duties, the vast majority of care providers responded positively. Between 80% and 90% feel that helping others strengthens their relationships with the care receiver, and repays some of what they themselves have received from others and from life. It is encouraging to learn that Canadians look upon these duties in a positive light, especially since looking after a frail senior can affect the caregiver in more negative ways.

For example, many middle-aged caregivers have had to change arrangements for social activities and for holidays in order to discharge their care giving responsibilities. More than one third incurred extra expenses. In addition, a substantial number of middle-aged caregivers reported changing their work patterns, including working split shifts and reducing hours of work.

A caregiver's duties can also have physical consequences, which were twice as likely to be felt by women, regardless of their age. One in 10 middle-aged men reported that their sleep patterns had been disrupted because of their caregiving activities, compared to two in 10 women; similar proportions of men and women indicated that their health had been affected. The same gender differences were recorded among caregivers 65 years and over, as 13% of women and 7%[E3] of men reported disrupted sleep, and 16% of women and 7%[E] of men felt that caregiving had affected their health.

Summary

The results of GSS 2002 show that there are two main sources of unpaid, informal care for seniors with long-term disabilities or physical limitations: the first is middle-aged children helping to care for their parents, and the second is seniors who are looking after each other.

The average middle-aged caregiver is 54 years old and is looking after a parent or parent-in-law with a long-term disability or physical limitation. In contrast, the average older caregiver is 73 years old and is looking after a spouse, close friend or neighbour.

The impact of care giving on those looking after seniors with long-term health problems is not inconsequential. The challenge is to offer support for the growing numbers of seniors who require both informal and formal services to remain autonomous.

1. Each caregiver is providing help to an average of 1.3 seniors.
2. Three-quarters (77%) of male caregivers aged 45 to 64 reported that their main activity was working at a job or business; almost all (93%) worked 30 or more hours per week. The majority of female caregivers aged 45 to 64 years were also working (63%), most full-time (72%).
3. E: Use with caution.

Source: Canadian Social Trends, Autumn 2004, No. 74

New Compassionate Care Benefits

As of January 2004, caregivers who have to be absent from work to look after a "gravely ill" family member can receive compassionate care benefits (CCB) for up to six weeks. To be eligible, caregivers must show that their weekly earnings have decreased by more than 40 per cent and that they have accumulated 600 insured hours in the last 52 weeks. For more information, visit **www.hrdc-drhc.gc.ca/er ae/pubs/ compassionate_ care.shtml**.

Source: Rehab & Community Care Medicine Spring 2004

Canadian Social Trends (CST) Compassionate Care Benefits

The federal government expanded the Employment Insurance (EI) program to extend compassionate care benefits to a person who must be absent from work to provide care or support to a gravely ill family member. Benefits may be paid up to a maximum of six weeks to an employee looking after a loved one who is at risk of dying within 26 weeks. Unemployed persons on EI can also ask for this type of benefit. Benefits can be shared with other members of the applicant's family, but they also must be eligible and must apply for them.

Under the new program, a family member is defined as: your child or the child of your spouse or common-law partner; your wife/husband or common-law partner; your father/mother; your father's wife/ mother's husband; the common-law partner of your father/mother.

Providing care or support to a family member means providing psychological or emotional support; arranging for care by a third party; or directly providing or participating in the care.

More information is available on the Social Development Canada Web site, at **www.sdc.gc.ca**.

Caregiver tax credit

Canada Revenue Agency (CRA) allows Canadians to claim deductions and credits for individuals supporting people with disabilities. For example, care could have been provided to parents, parents-in-law and grandparents. The caregiver amount is a non-refundable tax credit which reduces the amount of federal income tax paid.

For more information, consult the CRA Web site at **www.ccra-adrc.gc.ca**.

Source: Canadian Social Trends
Autumn 2004 - No. 74

SELF CARE

At the doctor's office … What to do about waiting

A 20-minute wait in a doctor's office is all some people will tolerate before they start holding a grudge.

Tips to help you avoid holding a grudge against your doctor:

- Try to get the first appointment of the day, or the first one after lunch.
- Call before you leave to see if your doctor is running on time. Tell your doctor's office staff that you can't wait more than ___ minutes.
- Bring something to do while you wait (i.e., answer a letter, read a book, etc.)
- Make a written list of comments and questions to discuss with your doctor. This may not prevent you from waiting, but it should improve the efficiency of your appointment – and may keep someone else from having to wait.
- Have patience. A doctor who takes the time to probe your concerns carefully may be worth the wait. He or she may have spent some extra time with previous patients, which is why you are waiting.

Source: David S. Starr, MD, JB, MBA,
"Don't Keep Them Waiting," Cortlandt Forum

Inner Light

"People are like stained glass windows. They sparkle and shine when the sun is out, but when the darkness sets in, their true beauty is revealed only if there is a light from within."

- Elizabeth Kubler-Ross

Stress Less … Learning to be assertive

Many of us have a heard time being assertive—or even understanding what assertive behavior is.

In part, it's because we've learned mistaken assumptions about healthy behavior. If you see yourself in the left-hand column, try to change your thinking and behavior so that it's more in line with that in the right-hand column. It's your right!

Mistaken assumptions	Legitimate Rights
It's selfish to put your needs before others's needs.	You have a right to put yourself first sometimes.
It's shameful to make mistakes.	You have a right to make mistakes.
If you can't convince others that your feelings are reasonable, then they must be wrong, or maybe you are going crazy.	You have a right to be the final judge of your feelings and accept them as legitimate.
You should respect the views of others, especially if they are in a position of authority. Keep your differences of opinion to yourself. Listen and learn.	You have a right to have your own opinions and convictions.
You should always try to be logical and consistent.	You have a right to change your mind or decide on a different course of action.
You should be flexible and adjust. Others have good reasons for their actions, and it's not polite to question them.	You have a right to protest unfair treatment or criticism.
Things could get even worse, so don't rock the boat.	You have a right to negotiate for change.
You shouldn't take up others' valuable time with your problems.	You have a right to ask for help or emotional support.
People don't want to hear that you feel bad, so keep it to yourself.	You have a right to feel and express pain.
You should always try to accommodate others. If you don't, they wont' be there when you need them.	You have a right to say "no."
Don't be anti-social. People are going to think you don't like them if you say you'd rather be alone instead of with them.	You have a right to be alone, even if others would prefer your company.
When someone is in trouble, you should help someone else's problem.	You have a right not to take responsibility for them.
You should be sensitive to the needs and wishes of others, even when they are unable to tell you what they want.	You have a right not to have to anticipate others' needs and wishes.
It's always a good policy to stay on people's good side.	You have a right not to always worry about the goodwill of others.

Source: The Relaxation and Stress Reduction Workbook (Third Edition) by Martha Davis, PhD; Elizabeth Robbins Eshelman, MSW; and Matthew McKay, PhD

What else is there to do when you are old?

Lise Dallaire Durocher, Retired

"Look, stop, this moment is beautiful! Is there anywhere else, in all of your life that is rushing by, a sun as blond, a lilac so blue from being purple, a book so passionate, a fruit so full of sweet purfume, a bed so fresh with white and rough sheets? Will you ever again see these hills as beautiful as they are now? How long will you still be that child, drunk with life itself, withthe beat of your happy arteries?"[1]

Growing old is a privilege however it is a troubling and demanding experience. In younger years, this truth rarely comes to mind. At retirement, the official threshold of becoming old, people we meet congratulate us on finally knowing the pleasure of "perpetual holidays". We must then defend ourselves for having deserted the work force or accept the subtle disdain reserved for retired people. Work is the measure of an adult's value; seniors have no place in this concept. Social decline therefore often occurs prior to biological decline. Consequently, some people feel the need to justify aging.

We must prepare ourselves to see in other people's eyes the "signs of aging", which take over, progress and are inevitable. We must humbly accept to be helped and smile discretely when young people express their astonishment at our endurance in spite of our advanced age. We regularly hear in the media of an increasing number of people who have decided to rejuvenate their image by undergoing surgery that may at times be draconian. How have we come to this masquerade? Is the point not to modify in other people's regard, a reflection deemed socially acceptable?

A healthy life style can be very useful but it cannot, unfortunately, protect us from all age related problems. Who is not aware that arthritis, rheumatism, hypertension and mental health problems are the leading health problems of seniors? The escalation of care at all cost reassures us but frightens us at the same time as the specter of dementia scares us even more. We are increasingly aware that our well-being depends on our physical and mental health because they are interdependent. They are also directly related to our social condition. Furthermore, we are increasingly aware that we are not solely responsible for our state of health. The precarity of these components is very troubling. Who can say that he or she is aging well or that he or she will age well?

Upon retirement, we often have projects that would take two lifetimes to accomplish, much like we do every weekend or vacation. Time is not an elastic and choices must be made to coincide with our aptitudes; our time needs to be managed while maintaining our desire to meet challenges.

We also have a duty to dedicate ourselves to the essential tasks of aging. Many authors have described these tasks. Thus, we need to adjust to retirement without feeling "discarded" and of course with less income. We must adapt to our declining strength and to a more fragile health; we must adapt to an eventual loss of autonomy and to a slowing down of our physical and intellectual responses. Around us, loved ones are stricken with illnesses or die; evidence of decrepitude and death becomes obvious to us. There are many goodbyes. We must learn to live alone while maintaining as much autonomy as possible. At the same time, regardless of how old we are, we must still find the energy to reorganize our physical environment, to face possible placement and to act accordingly (analyze the situation, obtain the necessary information, explore options). To compensate for the changes of environment, energy and role, we will need to undertake new activities, to develop new relationships and to set new objectives for ourselves. Age makes us more vulnerable to physical and emotional stress; we must live with this new weakness and learn to face our own death. These are not easy or simple tasks. We have one life that has a beginning and an end and if we were not yet aware of it, everything contributes to becoming a little older each day.

All human beings have a need to be useful. Luckily, it is possible to meet our various needs in our own way, without searching high and low. Though it may not be wise to become trapped in full time pseudo-volunteer work, many people have been able to lighten their burden of days that are too long. Furthermore, helping out is good for one's self esteem and provides social approval. Advanced age and experience allow us to be more daring, to experience events with more

humor and indulgence, to listen better and at times to offer advice. As we help out, we discover new interests. Action maintains physical and mental fitness, allows for socialization and to regain the satisfaction of being useful. Of course, this takes effort; nothing is gained without effort. Old age is not the plenitude of childhood; each day the curtain goes up one more time though we have always known it must go down for good. Facing honestly the ups and downs of aging helps our western mind to come to terms with the facts.

As for myself, I love life and enjoy each minute that is offered to me. I sing a lot, I laugh as often as possible, and I read the philosophers and try to integrate a bit of their wisdom. Walks in the mountains allow me the time to think about all that has changed in my life. I have the joy of seeing my children's children growing up and developing. At times, I contribute to their discoveries and I write for them so they will know who we were and how we lived before them. I listen to those around me who need to be listened to, as I selfishly believe that I will learn from it. I am passionate about fairy tales, history, trips on my own and long walks in unknown cities. Relating these passions puts a little color in the lives of people who are bored or sick. And God willing, if one day the body betrays us, the beautiful images, the perfumes and the music we have experienced will reverberate in our minds. We, must therefore, take advantage of each moment of our short lives.

1 Colette, La retraite sentimentale

Source: Vital Aging
Volume 10, Number 2, June 2004

LEGAL ISSUES

Beyond Conjugality

Recognizing and supporting close personal adult relationships

Published by: The Law Commission of Canada

Canadians enjoy a wide variety of close personal relationships—many marry or live with conjugal partners while others may share a home with parents, grandparents or a caregiver. The diversity of these relationships is a significant feature of our society, to be valued and respected. For many Canadians, the close personal relationships that they hold dear constitute an important source of comfort and help them to be productive members of society.

The law has not always respected these choices, however, or accorded them full legal recognition. While the law has recently been expanding its recognition beyond marriage to include other marriage-like relationships, it continues to focus its attention on conjugality. The Law Commission believes that governments need to pursue a more comprehensive and principled approach to the legal recognition and support of the full range of close personal relationships among adults. This requires a fundamental rethinking of the way in which governments regulate relationships.

The diversity of personal relationships formed by Canadian adults is not a new phenomenon. Alongside the nuclear family centred on the conjugal couple, there have always been a variety of other living arrangements, including adult siblings sharing a home, widows and widowers forming blended families and multigenerational households. While domestic relationships appear to have become more diverse over the past thirty years, it may simply be that public awareness has increased as a result of the increased availability of statistical data. For example, the 2001 census was the first time that Statistics Canada collected data on same sex unions. Many non-conjugal relationships are still largely invisible in mainstream social science research. As well, we have only limited information about relationships where adults are economically, emotionally and even physically interdependent, but do not share a residence.

For more information and to obtain a copy of this book contact:

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Transforming Relationships Through Participatory Justice

Learning from Conflict

Conflict is an enduring feature of our lives. We experience it in our families, at work, at school, all around us, all the time.

Conflict can cause pain and loss. It can damage people and property, sometimes irreparably. It also has the potential to destroy relationships. But conflict can also have positive effects. By working to resolve conflict, we can learn to appreciate and understand the interests and concerns of others. As a community, how we resolve conflict helps us define the values that underpin the rules and regulations that guide our lives.

As individuals and as a society, we can adopt a number of strategies to resolve conflict: some are healthy; others are not. Frequently, we turn to the courts to resolve our disputes. However, courts and tribunals are sometimes perceived as unresponsive to the needs of people in conflict; disputes are framed in legal language that does not always reflect how individuals experience them; remedies often do not provide adequate redress; and the process can be time-consuming, costly and confusing.

The adversarial framework, a dominant feature of Canadian law, is increasingly seen as lacking flexibility. Our adjudicative system although committed to principled and just outcomes, often fails to meet the needs of the parties involved in the conflict or the best interests of the larger community.

The Commission's report, *Transforming Relationships Through Participatory Justice*, is the culmination of its consultation and research. It examines Canada's current experience of participatory justice, offers guiding principles for designing and evaluating participatory justice processes, and sets out recommendations for achieving a culture of participatory justice.

For more information, or to order a copy, contact:
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PUBLICATIONS AND WEBSITES

Workplace Health

Many business owners realize the importance of looking after their employees' well-being and satisfaction in the workplace. Now, owners have helpful advice at their fingertips with *Healthy at Work*, a new pocket-guide resource.

This 212-page handbook provides owners successful, proven strategies on nutrition, exercise, stress reduction and the treatment of common ailments. It also explains cost-effective treatments and dispels familiar medical myths.

Healthy at Work can help organizations reduce absenteeism and control health care costs.

To order call Books for Business at
1-800-668-9372

Source: Rehab & Community Care Medicine
Spring 2004

Thesaurus of Aging Terminology 7th Edition, 2002

The *Thesaurus of Aging Terminology* is a controlled vocabulary of subject terms used to index journal articles, books, book chapters, and videos cited in the AgeLine Database. AgeLine is an online, bibliographic database produced by AARP (formerly the American Association of Retired Persons) that focuses on the subject of aging and middle-aged and older adults, particularly addressing the social, psychological, economic, policy, and health care aspects of aging. AgeLine can be accessed via the Internet at **www.aarp.org/ageline** or **www.research.aarp.org/agelin** and through online search services or CD-ROM at many libraries.

The *Thesaurus of Aging Terminology, 7th Edition* may also be ordered for a $10.00 prepaid shipping and handling fee (cheque made out to AARP) from:

AgeLine Database Research Information Centre
AARP

601 E Street NW, Washington, DC 20049.

Innovations in Housing

Maintaining Seniors' Independence Through Home Adaptions: A Self-Assessment Guide

The overwhelming majority of seniors wish to continue to live in their own homes for as long as possible. However, many homes are not well designed to meet our changing needs as we age.

This publication identifies the types of difficulties that seniors can experience and describes types of adaptations that can help overcome these difficulties.

Each of the sections of this guide, listed in the Table of Contents, deals with an activity in the home. In using each section of the guide, first decide whether you are having difficulty with the described activity. If you are, examine the types of adaptations described in the section and decide whether any could help you. If you can think of a useful adaptation that is not described in the guide, you can write a brief description in the appropriate section, so that you have a complete record of the adaptations you are considering.

Although this guide is designed to assist you in assessing your own needs, you may wish to ask a family member or friend to help you answer the questions. Sometimes a second pair of eyes will spot something you have overlooked.

For further information contact:
Canada Mortgage and Housing Corporation
Regional Offices
Tel: 1-800-668-2642
Fax: 1-800-245-9274
Web site: www.cmhc.ca

Maintaining Seniors' Independence Through Home Adaptions: A Guide to Home Adaptations

Home Adaptations for Seniors' Independence (HASI)

This program helps homeowners and landlords pay for minor home adaptations to extend the time that low-income seniors can live in their own homes independently. Low-income eligible seniors with age-related disabilities can obtain assistance in the form of a forgivable loan up to $3,500 for minor adaptations that meet their needs.

Residential Rehabilitation Assistance Program for Persons with Disabilities (RRAP-D)

If your home requires extensive modifications, such as widening doorways and increasing space for wheelchair maneuvering, you may qualify for financial assistance under this program. RRAP-D is intended for low-income homeowners and renters with disabilities.

For further information contact:
Canada Mortgage and Housing Corporation
Regional Offices or
Tel: 1-800-668-2642
Fax: 1-800-245-9274
web site: www.cmhc.ca

At Home With Alzheimer's Disease: Useful Adaptations to the Home Environment

The suggestions contained in this booklet are based on the results of a study on the ways in which private homes may be adapted for Alzheimer's (AD) patients and their caregivers. The suggestions are clustered into four groups, according to the intent of the practical changes:

- to increase the safety and security of AD persons;
- to adapt to their wandering, pacing and confusion about where they are;
- to prevent or reduce their anxiousness and restlessness; and
- to meet caregivers' needs.

Naturally, not all of the following suggestions will be appropriate, especially since sameness and familiarity at home are very important to persons with AD. Too many changes may upset them. Nor may all the changes be affordable, especially for caregivers who are pensioners.

If even a few of the suggestions given in this booklet are carried out, however, the amount of time required to supervise the AD patient, and the intensity of that attention, can be reduced. This may relieve the stress and exhaustion experienced by caregivers.

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Regional Offices or
Tel: 1-800-668-2642
Fax: 1-800-245-9274
Web site: www.cmhc.ca

Persons with Disabilities Online

is an access point for information on disability-related programs and services.

This site accesses a wide range of disability related information, featuring:

- accessible transportation
- adaptive technologies
- mapping fro the visually impaired

For more information visit:
www.pwd-online.ca

Evaluation of the Québec System of Financial Security at Retirement in Relation to that of other Industrialized Countries

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Law Commission of Canada Publications List

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Does Age Matter? Law and Relationships Between Generations Discussion Paper

A Law Commission of Canada Discussion Paper

Voting age. Mandatory retirement. Auto insurance rates. Drivers' licences. Access to health care.

Age is often used to confer a benefit like the right to vote or the right to a pension. Age is also used to restrict people through, for example, movie ratings or mandatory retirement. Most age-based laws focus on children, youth and older adults.

Did you know? In some provinces, you can't make a human rights complaint until you are 18 or 19 years old.

Did you know? Some older adults are denied health care services because their condition is "just part of aging".

Did you know? In some provinces, youth under the age of 18 receive a lower minimum wage than adults.

Did you know? People are often forced to retire at 65, even if they can't afford it.

Some of these laws and policies reflect stereotypes. Age is often used in law instead of ability, lack of maturity, vulnerability or illness. For example, laws that require 80 year-old drivers to undergo medical

exams are not about age, they are about being healthy enough to drive. Children often cannot participate in legal matters because the law assumes they are unable to understand them. But is that true of all children, young people and older adults?

Don't some of these laws reflect incorrect assumptions and stereotypes?

Laws and policies often treat everyone in these age groups the same and do not recognize differences between people. They sometimes assume that people follow a standard path through life: children and youth live with their parents while they go to school; adults work full time and have a family; older adults retire at 65 with a pension. Not all people follow that path; those who are different often fall through the cracks. Some youth may be living on their own at 16. Women and older immigrants may not have worked enough years to afford retirement by age 65.

These laws and policies can affect relationships between the generations. In a direct way, for example, governments consider parents' income when they decide the amount of a student loan.

Using age categories also emphasizes differences—people may not recognize the similarities they share with another age group. Older adults and children are both considered 'dependent' because they are not part of the paid workforce, even though they contribute to society and community in many other ways.

Age is usually easy to determine. A convenient criterion, it might also be appropriate in some laws and policies. But, are all age-based laws fair? Would financial need or ability be better criteria in some instances? Should our activity—whether we are in school, at work or taking time off—matter more than our age? How can we avoid assumptions and stereotypes, so that children, youth and older adults are treated with dignity and respect as full and equal participants in society?

These are some ideas to think about. The Law Commission of Canada wants to hear from you:

"When in doubt, tell the truth."

- Mark Twain

Does Age Matter?

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YOUR HEALTH

Cold and Flu Facts

Colds

- Colds are not caused by cold air, drafts, or getting wet or chilled.
- Antibiotics won't help a cold, because it's a viral infection.
- Cold symptoms usually worsen during the first three to five days, then gradually improve. But it's normal for coughs to linger for two or three weeks.
- Frequent hand-washing is one good defense against colds.

Flu

- People with the flu virus can be contagious at least a day before they show symptoms, and up to four days after their symptoms begin
- The flu virus is very contagious. You can become ill from 18 to 72 hours after exposure.
- The flu is a major misery. And it can be life-threatening for older adults or those with chronic illnesses. That's why it's a good idea for over 50 to get a flu shot.
- The best time to get a flu shot is in late October or November.
- The flu is caused by a virus and cannot be made better with antibiotics. These drugs are good only for fighting bacteria.

'The flu shot gave me the flu'

Well, technically, that can't happen. But a few people who get a flu shot report feeling sick, like they have a mild case of the flu. What's going on?

The flu shot vaccine is made from inactivated virus, so it can't cause the flu. But it occasionally does produce symptoms that mimic a viral illness. Symptoms can include various combinations of red eyes, cough, wheeze, sore throat, fever and fatigue, and even facial swelling. Symptoms can start within several hours of getting the shot and last about 24 hours.

One Canadian study reported that people who got sick after their shot were more likely to be receiving the vaccine for the first time. And one particular brand of vaccine appeared to be associated with more symptoms than other brands.

In any case, if you do get sick after your shot, know that it is not the flu and that you should feel better within 24 hours or so.

Bottom line: You're not likely to get sick after a flu shot. But even if you do, it's probably still better than becoming ill with the flu, which makes you very miserable and lasts far longer.

Source: Clinical Infectious Diseases
Vol. 36, Pg. 705

Carbohydrates: Getting a Bad Rap

We find carbohydrates in so many of our everyday foods. They are found in fruits, vegetables, grains, breads, dairy, and many more foods. These foods have been getting a bad rap for a long time however. Many people believe that carbohydrates cause us to gain weight and cause a number of ailments. Hence the high protein, low carbohydrate diets. This, even as studies are showing that diets that are high in carbohydrates are also effective in weight loss (Carbohydrate News, 2002).

We have been hearing so much these days about the "evils" of carbohydrates that it's time to talk about the value and importance of them in our diet.

1) Carbohydrates are our main source of energy. When we eat carbohydrate containing foods they are broken down to glucose which is utilized for energy in our bodies.
2) Most carbohydrate containing foods are high in fibre. Fibre can help us feel full, can help decrease cholesterol and control blood glucose levels. It is also beneficial in controlling bowel functions and preventing certain cancers. Go for whole grain high fibre choices.
3) Foods high in carbohydrates provide a variety of vitamins and minerals that we need. Fruits and vegetables provide vitamin C, folate, potassium, B vitamins, vitamin A and many more. Grains, breads and cereals provide B vitamins and many vital minerals like iron, and zinc.

Remember that weight loss cannot be attributed to one nutrient alone (like protein carbohydrate). In fact you should be wary of diets label certain foods as "bad" or "off limits". Healthy, successful weight can be achieved by a diet balanced with all foods. Most weight loss diets work because they are essentially low calorie (even the high protein ones). The most successful ones however are those that promote variety by not limiting certain foods, promote activity and can be followed for a lifetime.

Source: Pete's Frootique Newsletter
November 2004

Cod liver oil and arthritis

Cod liver oil may help ease pain and slow the joint damage of osteoarthritis, say researchers. "By taking cod liver oil, people are more likely to delay the onset of osteoarthritis and less likely to need joint replacements later in life," explains lead researcher Bruce Caterson.
Editor's note: *Cod liver oil is rich in vitamins A and D, both of which can be toxic if taken in large amounts.*

So it's best not to take supplemental vitamins A and D while using cod liver oil. Also, your body makes vitamin D when sunlight hits your skin, so if you take cod liver oil in the summer minimize your sun exposure.

Source: Research from Cardiff University, Wales

Less salt, more potassium

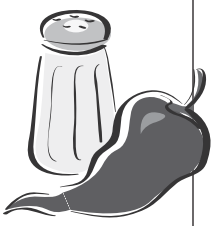
Less salt—and more potassium—can do rising blood pressures a world of good, say researchers.

New guidelines recommend a sodium intake of no more than 1,500 mg a day. This is less than the previous recommendation of 2,400 mg a day (about 1 teaspoon). Most of the salt in our diets comes from processed and restaurant foods.

To offset salt intake, adults should get at least 4,700 mg of potassium every day. At least five daily servings of fruits and vegetables can help you reach this goal, since they are low in sodium and high in potassium.

Foods with the highest potassium content include spinach and other dark leafy greens, cantaloupes, bananas, oranges, tomatoes, almonds, winter squash, potatoes, and beans. dairy products are another good source.

Source: National Academies of Science, February 11, 2004



Sugar Math

You'd be amazed how much sugar is added to many processed foods. For starters, a 20-oz. bottle of cola contains the equivalent of about 14 teaspoons of sugar.

But most food labels list sugar in grams, a measurement that we're not very familiar with.

So, to convert grams to teaspoons, do this simple math: Divide the grams of sugar by 5.

For example, if an 8-oz. carton of fat-free fruit yogurt has 43 grams of sugar, that works out to almost 9 teaspoons.

Surprised?

"Middle age is when your age starts to show around the middle."

- Bob Hope

Mammography Guidelines

Diagnostic Mammography: Physician referral

Women who are symptomatic (have new breast problems) should be checked by their family physician and possibly have a Diagnostic Mammogram arranged for them by the physician's office. A requisition must be completed. Physicians are required to fax requisitions for Diagnostic Mammograms for the Queen Elizabeth II Health Sciences Centre and the Cape Breton Regional Health Care Complex to (902) 473-3959 and a booking time and date will be assigned. The requisition will be faxed back to the doctor's office to be issued to the woman. These requisitions must indicate specific new signs or symptoms, or other reasons for diagnostic eligibility such as:

- Symptomatic
- Post Surgical Breast Biopsy (if less than one year)
- All post "benign" Core Biopsy follow-up mammograms until two years has elapsed
- All six month follow-up appointments
- Implant situations; past or present
- Pregnant or breast feeding
- Physically or mentally challenged
- Women with a personal history of breast cancer (may return to screening program if diagnosed over two years previously).

Screening Mammography: Self-referral

The Canadian Association of Radiologists (CAR) National Standards and Guidelines for Breast Screening recommend mammography screening for asymptomatic women at least 40 years of age.

- Minimum age 40
- No new breast symptoms
- Minimum 1 year since previous mammogram
- Resident of Nova Scotia with a Nova Scotia Health Card
- Pre HRT mammogram
- Fibrocystic, routine mammograms
- Women with a first degree family history of breast cancer ie: mother, sister, daughter, father, brother, son.

Frequency

- Women aged 40-49 should have annual screening.
- Women aged 50-69 should have mammography screening at two-year intervals unless they have a personal or family history of breast cancer. Provincial/ national guidelines recommended are evidence-based.
- Women over the age of 70 should have screening mammography at two-year intervals if they are in good health.

Ultrasound Guidelines

It is not recommended to use ultrasound as a screening tool. It may be utilized:

- For investigation of new solitary palpable masses, often prior to or instead of mammography.
- As an additional test if an abnormality is seen on mammography and does not demonstrate the characteristics of a benign process.
- As an initial test on women under the age of 30 if there is a palpable abnormality.

Six Month follow-up Mammography

If requested by the radiologist from a previous mammogram, six-month mammogram or ultrasound procedures should be booked by the family physician. Following these short-term follow-up requests, a return to routine screening is usual.

Benign Core Biopsy Protocol

- Six-months following the benign core biopsy a unilateral diagnostic mammogram is recommended.
- Twelve months following the benign core biopsy a bilateral diagnostic mammogram is recommended.
- Twenty-four months following the benign core biopsy it is recommended to resume regular guideline screening.

Atypical Core Biopsy Protocol

Treatment following a core biopsy with a histological diagnosis of "atypical ductal hyperplasia" is recommended to be similar to any borderline lesion. This should involve a surgical consult and probable excisional biopsy.

Aging in Atlantic Canada: Service Rich and Service Poor Communities

The delivery of services for seniors in Canada today is increasingly complex and challenging. Not only do communities across Canada age at different rates, the forces underlying the differences, such as aging in place and migration, vary from community to community. A pattern to two types of aging communities may be discerned: 'service rich' communities where on average seniors have higher health status and better amenities, and 'service poor' communities where seniors have poorer health status and limited amenities. In this paper, results from a study of service provisions for seniors in Atlantic Canada are reported. The paper focuses on three issues: the impact on communities of migration and aging 'in place'; the factors which distinguishes service rich and service poor communities and, the conditions necessary to create a service rich community.

Researched by: Jamie Davenport, MHSA, NS Department of Health; Thomas A. Rathwell, PhD, School of Health Services Administration, Dalhousie University; Mark W. Rosenberg, PhD, Department of Geography, Queen's University, Kingston, ON.

Myth: The aging population will overwhelm the healthcare system.

Fact: the proportion of Canadians over 65 is increasing. *Another fact:* the elderly need more medical services than younger people. Put together, these snippets of reality conjure up a familiar image, where healthcare costs of the aging population in Canada balloon until the system gets blown away.

Despite that intuitive assumption, things don't quite work that way. Healthcare costs don't go through the roof just because there are more seniors. The real issue is with changes in the number and nature of medical services for elderly patients. [1]

The price of aging

Nobody disputes healthcare costs increase with more old people. But—provided use rates of the different age groups stay constant—this increase will happen along a gradual slope, easily cushioned by the economy. It won't swamp the system. In fact, the impact of the aging population will actually be quite small, says Morris Barer, a health economist at the University of British Columbia: about one per cent each year in total healthcare costs for the whole population.[2]

Where do all the costs come from?

The most dramatic role in the aging "crisis" isn't played out in the numbers of the elderly but in changing patterns of health services utilization. Namely, heavier, more intense treatment for those over 65.

Researchers studying the use of health services found that in 1995/96 (figuring in hospital downsizing effects), almost one-third of all inpatient days in British Columbia hospitals were provided to the young and the middle aged. The remaining two-thirds went to patients over 65.[3] That seems like the expected norm—but it's the flip side of what was happening about 25 years before, when young and middle-aged patients used about two-thirds of all inpatient days in hospitals, and seniors only used one-third.

In Quebec, between 1982 and 1992, the proportion of seniors grew from 8.9 to 11.2 per cent, while their costs of physician services more than doubled. Some of that increase can be attributed to higher physician fees and the growing numbers of seniors. However, the main reason was that seniors had radically upped their visits to the doctor within the 10 years.[4]

In other words, it isn't the number of the elderly driving the increase in healthcare costs—it's that they're using healthcare services more and more. But why? Are the elderly now much sicker than they used to be? Or, is the system treating geriatric health needs very differently than before?

The elderly: healthy and unhealthy

At first glance, the former scenario seems to explain it all. It's true people are living longer, but they spend a greater proportion of their years after 65 in ill health.[5] Manitoba researchers found that not only did the number of elderly people in the province increase between the early 1970s and 1980s, more of them were living in poor health.[6] More sick seniors: that seems to justify the need for more services … but the big picture tells a different story.

Despite the rising numbers of the elderly in ill health, it's actually healthy seniors who have driven the most significant increases in healthcare use: their visits to the doctor went up by 57.5 per cent, far more than unhealthy seniors increased theirs. The fact that there were more sick seniors played only a small role in the drastic increase in healthcare use among the elderly, the researchers conclude.[7]

Increase in medical use by seniors in good and bad health

Why are healthcare costs for the elderly rising so rapidly? Between 1971 and 1983 in Manitoba. seniors in good health got many more medical services than unhealthy seniors. Healthy seniors accounted for a 57.5 per cent increase in specialist care and a 32 per cent increase in non-specialist care, while elderly individuals in bad health accounted for 10 and nine per cent respectively.

Data from Black C et al. 1995. "Rising use of physician services by the elderly: The contribution of morbidity" Canadian Journal on Aging: 14(2): 225-244.

The question at large

Why are seniors given so much more treatment than they used to get? It's a question that needs to be asked, especially since this increase is even more striking compared to the healthcare use of other age groups, which may have been growing—but certainly at a much lower rate. Is intensified care for healthy elderly people appropriate and necessary? William Dalziel, the head of geriatrics at the University of Ottawa, notes the value in routinely giving the elderly procedures such as flu vaccinations, Cataract surgeries and hip replacements.[8] But more research needs to be done, he says, to identify procedures that truly improve living standards for the elderly.

1. McGrail K et al. 2000. "Age, costs of acute and long-term care and proximity to death: evidence for 1987-88 and 1994-95 in British Columbia." Age and Aging; 29: 249-253.
2. Barer ML et al. 1995. "Avalanche or glacier? Health care and the demographic rhetoric." Canadian Journal on Aging; 14(2): 193-224.

3 McGrail, KM et al. 1998. "The quick and the dead: The utilization of hospital services in British Columbia, 1969 to 1995/96." University of British Columbia, Centre for Health Services and Policy Research; HPRU 98:3D.

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Source: Mythbusters
Mythbusters are prepared by Knowledge Transfer staff at The Canadian Health Services Research Foundation and published only after review by a researcher expert on the topic.

Community Occupational Therapy: Working with Nova Scotians

When I recently helped my elderly neighbour come home from the hospital following a fall-related fracture, I was able to use my experience as an occupational therapist. We taped down the edge of his carpet so his walker wouldn't catch it, got equipment so he could bathe safely, arranged for an emergency alert system and Meals on Wheels. He had no one else to help. Even after years of similar visits as a community occupational therapist, I had a new insight into what individuals and caregivers might experience returning home following a hospitalization or dealing with a chronic condition. The sense of responsibility and uncertainty about how to handle the situation can be intimidating and overwhelming. This is where I believe community occupational therapy can assist seniors in Nova Scotia.

Occupational therapy is a health profession that enables people to do what they need and want to do to make life meaningful. This includes those activities we perform to take care of ourselves (e.g. bathing, dressing), participate in paid or unpaid work (e.g. meal preparation, volunteering), and leisure activities. Occupational therapists work with a variety of individuals including those who live with the effects of aging, mental illness, or physical disability. Providing support and recommendations to caregivers is an essential part of their intervention.

Many occupational therapists work with seniors in their community. An occupational therapist may be involved in teaching caregivers proper and safe techniques for lifting a person with a physical disability. They can develop a therapeutic program for a person living at home with Alzheimer's disease, or may recommend home adaptations to help prevent falls. Seniors who wish to remain in their own homes may benefit from learning safe methods to manage their daily activities, checking that the home environment is as safe as possible, and developing community support systems.

Occupational therapists are often involved with the recommendation of equipment to maintain or regain independence with home, leisure and work activities. This may include customized wheelchairs, or bathroom equipment such as tub seats and grab bars. Appropriate equipment is one factor in assisting, for example, persons with a stroke or hip replacement, to return safely to a meaningful life in the community following discharge from the hospital. Rehabilitation programs may be established or followed up after hospitalization. The individual and their caregivers are educated and supported through the process.

Across Canada, community-based OT has been key in preventing hospital admissions and reducing the length of stay in hospital. Studies have shown that including occupational therapists in Home Care programs is an effective way of enabling people to remain safely in their own homes, avoiding admission to long-term care.

Unfortunately, Nova Scotia is the only province in Canada that does not have OT services available as part of its Home Care program. There are some publicly funded community occupational therapy services affiliated with hospitals, but the availability, particularly outside of HRM, is limited.

The vision for Home Care Nova Scotia when it was implemented in 1995 was to have rehabilitation services, including occupational therapy, included. In November 2002, the Romanow Report identified the need to establish a national platform on Home Care services. In February 2003, Canada's Health Care Renewal Accord had the Prime Minister and Premiers identify home care as a priority with the plan to determine a set of minimum standards provided under home care programs. To date, Nova Scotians are still waiting for our Home Care program to offer services available in the rest of the rest of the country.

The Nova Scotia Society of Occupational Therapists is dedicated to the improvement of Nova Scotians' access to quality and effective health care services. Asking for the inclusion of rehabilitation services, including occupational therapy, within our HCNS program is one action we can take to promote the health and well being of ourselves and those who are dear to us. We can ensure that all of our neighbours have equal access to the health profession that enhances "skills for the job of living".

If you have any questions or comments please contact:

The Nova Scotia Society of Occupational Therapists (NSSOT), 453-4537

Submitted by: Mary Ellen Sullivan, OTReg(NS) and Jennifer Freeman, OTReg(NS), Members of NSSOT

Prescription Drugs: Who Pays the Price?

Consumer access to affordable prescription drugs is at the forefront of the United States' domestic policy debate. To help inform the public debate using experiences of other nations, AARP's Global Aging Program held a one-day International Forum on Prescription Drug Policy. It examined how European countries, the United Kingdom, Australia, and Canada are attempting to contain costs, ensure adequate access to pharmaceutical products for consumers, and promote innovation among pharmaceutical companies.

Novartis AG Chairman and Chief Executive Officer Daniel Vasella, MD, addressed the conference stating the US does not spend too much on health care in general or on drugs in particular. He noted that government policies are helping to make the US the primary engine for research and development (R&D) in the pharmaceutical industry worldwide. He also believes that these policies and high levels of R&D spending are having a positive impact on the US economy and on US consumers, who enjoy quicker access to new therapies.

Calling on the US Congress to pass a drug benefit under Medicare, the US public health insurance for persons age 65 and over and some persons under 65 with disabilities, Vasella said, "I think it's an anomaly that in the US, the most needy people [who] are the seniors do … not have the coverage." He also urged governments throughout the world to enact policies to accelerate drug development and speed regulatory approvals so that patients gain faster access to needed drugs.

Dr. EM. Scherer, Professor Emeritus at the John F. Kennedy School of Government at Harvard University, contrasted the US pharmaceutical industry with that of other countries, noting that the US has lower rates of overall insurance coverage, a higher degree of generic substitution, and relatively weak price controls. Yet he cautioned lawmakers about designing policies that control the price of pharmaceuticals, because such laws could reduce innovation in the US, the biggest supporter of R&D in the world, and potentially raise prices of drugs in third-world countries. Specifics of the European Union, United Kingdom, Australian and Canadian models for controlling drug costs while ensuring access, offered a variety of policy options for the US.

Europe's approach to facilitating access to prescription drugs includes several features such as: near universal public coverage of drugs with a limited role for private insurance; national formularies; strong regulation of drug prices; modest co-payments with exemptions for certain vulnerable populations; no direct-to-consumer advertising; and increasing "parallel trade" where prescription drugs manufactured in one EU country are freely sold in other EU countries. Dr. Panos Kanavos of the London School of Economics

noted Europe's lesson for the US is the importance of creating the right incentives for stakeholders to control costs, promoting evidence-based use of pharmaceuticals, and considering greater use of "reference pricing," where prices are pegged to a benchmark drug of similar therapeutic value.

The UK government's approach was to develop a 10-year strategic and funding plan that called for greater use of generic drugs and instituting a quality framework that focused on evidence-based medicine and guidelines. Under the auspices of the National Institute for Clinical Excellence (NICE), stakeholders such as experts and physicians determine how effective and efficient a product is once on the market and then create guidelines for appropriate use. The 10-year plan also monitors the extent to which the National Health Service providers are complying with national standards.

Australia's method for drug cost containment relies heavily on a national formulary. Manufacturers apply to be placed on the formulary with a suggested price for their product. New drugs are then evaluated with respect to their cost-effectiveness versus alternatives available at the suggested price. For drugs placed on the formulary, reimbursement is provided only when appropriate guidelines for usage are followed. Whether the Australian guidelines have successfully controlled costs is unclear, yet the system does seem to get appropriate drugs to those who need them.

Canada's federal Patented Medicine Prices Review Board (PMPRB) reviews drug prices and uses established, transparent guidelines to ensure that the prices charged by manufacturers of patented medicines are not excessive. In addition to the PMPRB, provincial plans playa critical role in controlling drug costs in Canada. Provincial plans account for about 40 percent of all pharmaceutical spending. The provincial plans include a formulary with a list of drugs that the plans will reimburse.

AARP's Director of Policy and Strategy John Rother drew out several lessons for the US First, there's an inevitability that the US should start to address pharmaceutical pricing, but in a broader context that includes the impact on total health costs, clinical outcomes, and economic growth. Many trade-offs exist in developing such policies, and no one approach can simply be "lifted" wholesale from abroad – there is no single "magic bullet."

Rother also pointed to the need for tools to promote use of information that compares drug efficacy and cost effectiveness.

AARP CEO, Bill Novelli, stated that other countries offer the US valuable guidance with respect to access, affordability, and maintaining incentives for innovation. "After more than a decade of missed opportunities on prescription drugs, and more than a decade of rising drug costs, the time has come here in the United States to find solutions," Novelli proclaimed.

Source: Global Report on Aging
Premier Issue, Fall 2003

NOTES OF INTEREST

Environment

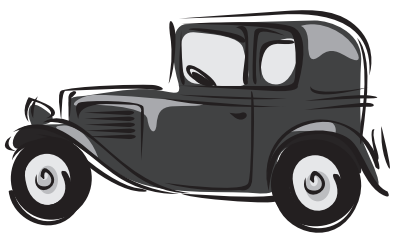
Your driving habits: Get greener

Air pollution is a fact of life in urban and suburban areas. And much of it comes from our vehicles.

To cut back on pollution no matter what vehicle you drive:

- Lighten up on the lead foot. One second of high-powered driving produces nearly the same volume of carbon monoxide as a half-hour of normal driving.
- Drive smoothly. Accelerating and braking hard wastes gas, wears down your brakes, and increases emissions.
- Slow down. Driving 65 mph instead of 75 increases your gas mileage by about 10%.

Source: American Council for an
Energy-Efficient Economy



Why is it so difficult to combat elder abuse and, in particular, financial exploitation of the elderly?

by: Donald Poirier and Norma Poirier

The scientific community and the population as a whole are now aware that financial exploitation is the most common form of elder abuse. Yet, helping professionals continue to present all forms of elder abuse as a single problem similar to that of child abuse, with physical abuse and emotional or social neglect being its main characteristics. These professionals have therefore passed over in silence financial exploitation and have proposed legislative solutions modelled on child protection laws, notably those of the Atlantic provinces.

The authors of this report have undertaken to analyse why it is so difficult to effectively combat elder abuse, particularly the financial exploitation of the elderly. They do so in three stages. Firstly, the authors analysed the adequacy of the different components of Canadian law in this regard (provisions of the *Criminal Code*, of common law and of Quebec civil law, and of special legislation applicable to the elderly). They conclude that the Canadian law currently in effect is adequate to combat the various forms of elder abuse, including financial exploitation.

Secondly, they analysed the efficacy of the various components of Canadian law in combatting elder abuse, notably, financial exploitation. They conclude that the relevant components of Canadian law are ineffective mainly with regard to financial exploitation.

Thirdly, the authors construct a conceptual model to answer the question: "Why is it so difficult to effectively combat elder abuse and, notably, financial exploitation of the elderly?" In the conceptual context of normative pluralism, three hypotheses are proposed to explain the problem: the inadequacy of legal norms; the ineffectiveness of the professional standards of social workers; and the resistance of familial norms. After analysing the available empirical data, the authors conclude that each social system is driven by its own logic, which is not necessarily compatible with that of the others.

Now, according to Luhmann's theory of social systems, each social system is self-referential and can be defined only by itself and not by the others around it. Thus, while the social professions have succeeded in having adopted elder protection laws modelled on child protection, the social logic within these laws may well conflict with that of the *Canadian Charter of Rights and Freedoms* and be declared inoperative. Moreover, within the professional social system, social workers have redefined the problem of elder abuse as a single problem having a single solution other than those provided in the *Criminal Code*, thereby discrediting the work done by the police to combat elder abuse. Finally, the greatest challenge lies in the fact that the social system of the family is closed to the influence of social workers and, notably, to police intervention. Until traditional police and judicial law enforcement measures are shaped according to the logic of the social system of the family, the struggle against elder abuse, notably financial abuse of the elderly, is doomed to fail.

In order to succeed, the measures used, notably the alternative measures provided by the *Criminal Code* and in civil proceedings, must be more in keeping with the values of the familial social system.

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Abuse and Neglect of Older Adults and further information on family violence, contact:

The National Clearinghouse on Family Violence

Family Violence Prevention Unit
Health Issues Division
Health Promotion and Programs Branch
Health Canada
Address Locator: 1907D 1
7th Floor, Jeanne Mance Building,
Tunney's Pasture

Ottawa, ON KIA IB4 Canada

Tel: 1-800-267-1291 or (613) 957-2938
Fax: (613) 941-8930
website: www.hc-sc.gc.ca/nc-cn

International Federation on Aging: Part of a Worldwide Revolution

All over the world, a quiet revolution is taking place. The trend towards an aging population is becoming visible. Aging is one of the major policy issues in both developed and developing countries. This demographic event will impact on the lives of every man, woman and child around the world. As the Madrid International Plan of Action on Aging, 2002 states:

"The twentieth century saw a revolution in longevity. Average life expectancy at birth has increased by 20 years since 1950 to 66 years and is expected to extend a further 10 years by 2050. This demographic triumph and the fast growth of the population in the first half of the twenty-first century mean that the number of persons over 60 will increase from about 600 million in 2000 to almost 2 billion in 2050 and the proportion of persons defined as older is projected to increase globally from 10 per cent in 1998 to 15 per cent in 2025."

This revolution will affect everybody; it is not confined to the developed world. In fact, the greatest and quickest effects will take place in the developing world. The world as we know it will be transformed by this revolution and every aspect of our global society will have to change and develop as a result.

These profound changes are as a result of a trend of fewer children being born and people living longer. The fastest growing group of the population is the "oldest old" i.e. those aged 80 and above, and aging remains a predominant issue for women as they continue to live longer than men.

"Too often we... enjoy the comfort of opinion without the discomfort of thought."

- John F. Kennedy

Aging is a natural process of life. Older people are a valuable resource. They are the repositories of tradition, culture, knowledge and skills. These attributes are essential in maintaining intergenerational links. The vast majority of older people make vital contributions to their societies, families and communities as workers, caregivers, volunteers, mentors and as active citizens.

There are many challenges in this revolution and one of them is to not view this transformation as a "burden", but to see it as an amazing set of opportunities for us all.

For more information contact:

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Suite 520, 425 Viger Avenue West
Montreal QC H2Z 1X2

Tel: (514) 396-3358
Fax: (514) 396-3378
E-Mail: ifa@ifa-fiv.org
Website: www.ifa-fiv.org

Volunteer with the VON

Berwick, Aylesford or Kingston

The VON is currently enrolling volunteers to help with their Community Support programs. With a focus on helping seniors: Meals on Wheels, the Adult Day Centre, or the Foot Clinics, would greatly benefit from your help. VON staff and volunteers have been providing essential health care services for over 100 years. Call **678-3414** or **678-1733** for more information.

IFA Declaration on the Rights and Responsibilities of Older Persons

Preamble

The International Federation on Aging,

Appreciating the tremendous diversity in the situation of older persons, not only among countries but within countries and between individuals, which requires a variety of policy responses,

Aware that in all nations, individuals are living to advanced age in greater number and in better health than ever before, and

Persuaded by the scientific research disproving many stereotypes about inevitable and irreversible declines with age,

Convinced that a world characterized by increasing numbers and proportions of older persons must provide opportunities for willing and capable older persons to participate and contribute to the ongoing activities of society,

Mindful that the strains on family life in both developed and developing nations require support for caregivers of frail older persons,

Emphasizing that fundamental human rights do not diminish with age and

Believing that because of the marginalization and disabilities which old age may bring, older persons are at risk of losing their rights and being rejected by society unless these rights areclearly identified and respected,

Recognizing that without these rights, older persons cannot meet their desired responsibilities,

Bearing in mind the standards already set in the Universal Declaration of Human Rights, the International Covenants on Human Rights, and the International Plan of Action on Aging, as well as the adoption of other declarations to assure the application of universal standards to particular groups,

Now proclaims the following rights of older persons which should be secured to them by national and international action so that they may be protected and enabled to make continuing contributions to society, as well as the responsibilities which they acknowledge:

Rights of Older Persons

Independence

Older persons have the right:

1. to obtain adequate food, water, shelter, clothing and health care through the provision of income, family and community support and self-help.
2. to work and to pursue other income-generating opportunities with no barriers based on age.
3. to retire and participate in determining when and at what pace withdrawal from the labor force takes place.
4. to access educational and training programs to enhance literacy, facilitate employment, and permit informed planning and decision-making.
5. to live in environments that are safe and adaptable to personal preferences and changing capacities.
6. to reside at home for as long as possible.

Participation

Older persons have the right:

7. to remain integrated and participate actively in society, including the process of development and the formulation and implementation of policies which directly affect their well-being.
8. to share their knowledge, skills, values and life experience with younger generations.
9. to seek and develop opportunities for service to the community and to serve as volunteers in positions appropriate to their interests and capabilities.
10. to form movements or associations of the elderly.

Care

Older persons have the right:

11. to benefit from family support and care consistent with the well-being of the family.
12. to obtain health care in order to maintain or regain the optimum level of physical, mental and emotional well-being and to prevent or delay the onset of illness.

13. to access social and legal services to enhance capacity for autonomy and provide protection and care.
14. to utilize appropriate levels of institutional care which provide protection, rehabilitation and social and mental stimulation in a humane and secure environment.
15. to exercise human rights and fundamental freedoms when residing in any shelter, care and treatment facility, including full respect for their dignity, beliefs, needs, and privacy and for the right to make decisions about their care and quality of life.

Self-Fulfillment

Older persons have the right:

16. to pursue opportunities for the full development of their potential.
17. to access educational, cultural, spiritual, and recreational resources of society.

Dignity

Older persons have the right:

18. to be treated fairly regardless of age, gender, racial or ethnic background, disability or other status, and to be valued independently of their economic contributions.
19. to live in dignity and security and to be free of exploitation and physical or mental abuse.
20. to exercise personal autonomy in health care decision-making, including the right to die with dignity by assenting to or rejecting treatments designed solely to prolong life.

Responsibilities of Older Persons

Consistent with individual values and as long as health and personal circumstances permit, older persons should try :

1. to remain active, capable, self-reliant and useful.
2. to learn and apply sound principles of physical and mental health to their own lives.
3. to take advantage of literacy training.
4. to plan and prepare for old age and retirement.
5. to update their knowledge and skills, as needed, to enhance their employability if labor force participation is desired.
6. to be flexible, together with other family members, in adjusting to the demands of changing relationships.
7. to share knowledge, skills, experience and values with younger generations.
8. to participate in the civic life of their society.
9. to seek and develop potential avenues of service to the community.
10. to make informed decisions about their health care and to make decisions about terminal care known to their physician and family.

Source: The International Federation on Aging

UPCOMING EVENTS

International Conference on Patient Self-Management

Learn about new perspectives in patient self-management from the world's leading experts. Find out what the future holds in this rapidly growing field. September 12 - 14, 2005, Victoria Conference Centre, Victoria, BC.

For more information, abstract submission and conference registration, please go to: www.newperspectivesconf.com or contact Karin Ivand, Conference Planner at tel: (250) 652-5568; fax: (250) 652-5528

AARP - American Association of Retired Persons

New from AARP's Research Information Center! Internet Resources on Aging

www.aarp.org/internetresources. A searchable directory of more than 700 of the BEST Internet sites by and for older adults!

The web sites in AARP's Internet Resources on Aging are chosen for their usefulness for older adults and their families, as well as for researchers, students, and professionals in the field of aging.

We have done much of the work already to help you find the best information on the Internet by and for the 50+ population. Best of all, you can read abstracts about what a site offers before visiting it, saving much time and effort!

Sample Topic Areas:

- Aging Organizations, Directories, and General Interest
- Death and Dying
- Health and Well-Being
- Housing and Long Term Care Options
- Law and Legal Issues
- Research and Reference

Sample Subtopics:

- Health and Well-Being (78 sites)
- General Medical Information Sites (14)
- Health and Wellness (nutrition. fitness. preventive measures. etc.) (8)
- Health Insurance (9)
- Medical Conditions and Disabilities (24)
- Medicare and Medicaid (10)
- Mental Health and Emotional Support (5)
- Spirituality (8)

Logon to **www.aarp.org/internetresources** and get the resources you need to make the right decisions.

AARP

AgeLine Database **www.aarp.org/ageline** is a searchable database of over 65,000 book and article summaries on midlife and the later years, designed to meet your research, professional, and personal information needs.

AgeLine provides detailed content summaries of:

- Articles from over 300 professional and popular magazines and journals
- Books and chapters of scholarly, professional, and general interest
- Research reports and policy papers from academic, nonprofit, and international organizations
- Video summaries and contact information for purchase or rental
- Readable books for adults age 50+ on finances, employment, health, travel, retirement, family, personal growth

AgeLine is updated every two months; is current from 1978–present; is in English-only, international in scope; and is easy to use!

AARP Global Aging Program: Addressing World Aging Issues

Fact: We live in an aging world. Increased longevity and decreased birth rates are transforming societies and making an impact on our interconnected economies. This unprecedented demographic shift not only challenges many political and economic assumptions, but also enhance the aging population's contributions to society.

AARP was one of the first organizations to recognize aging as a truly worldwide phenomenon that requires global cooperation. Today, a world of interconnected economies undergoing a significant demographic shift—what some have called the graying of the world requires action by nation-states to ensure preparedness under these circumstances.

The AARP Global Aging Program facilitates understanding and dialogue around the global aging agenda by participating in the international social and economic policy debates worldwide.

What we offer:

- Commitment to add value to the global aging dialogue via groundbreaking demographic research and strategic advocacy expertise
- Unique perspective on ways to enhance and engage aging populations via fiscal and policy adjustments as well as positive social attitude changes
- Cooperation in identifying and establishing global "best practices" to promote older people's independence, participation in the work force and engagement in society.

Visit us on the web at **www.aarp.org/international** for the latest news, events and research engaging the 50+ population worldwide.

Questions about the AARP Global Aging Program and submissions for future issues of Aging Advances should be directed to **intlaffairs@aarp.org**.

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Bookmark the AARP Research Centre:
http://research.aarp.org/

"Patience is never more important than when you are at the edge of losing it."

- O.A. Battista

The Cognitive Impairment in Aging Partnership: uniting forces to improve health

an initiative led by: Canadian Institutes of Health Research

Cognitive impairment in aging (CIA), including Alzheimer disease and other types of dementia, affects one in four Canadians over the age of 65. The prevalence of cognitive impairment rises dramatically to two out of three Canadians over the age of 85. With our aging population, the number of cases of cognitive impairment is expected to double in Canada over the next 30 years, reaching epidemic levels.

The effects of cognitive impairment are far-reaching. Those who suffer from cognitive impairment experience a decline in their quality of life. The emotional suffering of their families and loved ones is considerable, and the financial burden on the health care system is significant.

While the need for cognitive impairment research is great, there are not enough researchers to meet the growing demand. The CIA Partnership, established in 2002, addresses this need by bringing together organizations with a shared interest in finding solutions.

Participants in the CIA Partnership

The participants are made up of a growing list of leading organisations from the voluntary, public and private sectors that have expertise in the field of research on cognitive impairment.

National Research Strategy

To reduce the prevalence and impact of cognitive impairment, the participants of the CIA Partnership have developed a National Research Strategy on cognitive impairment that aims to:

- build research capacity by training and attracting new researchers
- make optimum and efficient use of available resources of CIA partners
- co-ordinate research more effectively

- improve research infrastructure (teams, groups, centres, cohorts of subjects, neuro-imaging, brain banks, etc.)
- increase funding available through grants and awards to retain researchers
- implement initiatives to enhance the use of newly acquired knowledge through its translation into policy, practice, products and services

Scope of Research

Research conducted as part of the CIA Partnership's National Research Strategy covers a broad range of topics, disciplines and issues related to cognitive impairment including Alzheimer disease and other dementia such as vascular dementia:

- biomolecular basis
- neuropsychological aspects
- social, psychological and lifestyle influences
- normal vs. abnormal changes in cognitive function
- diagnosis
- natural history and influence of age, genetics, and environment
- epidemiology
- treatment (pharmacological and non-pharmacological)
- preventive strategies
- caregiving
- health services
- rehabilitation
- ethics
- quality of life

Accomplishments

After a short time, the CIA Partnership already has notable accomplishments in creating new funding opportunities for research on cognitive impairment in aging:

- Doctoral Awards (Alzheimer Society of Canada and CIHR Institute of Aging) **http://www.alzheimer.ca/english/research/resprog-compintro.htm**
- Young Investigator Grants (Alzheimer Society of Canada and CIHR Institute of Aging) **http://www.alzheimer.ca/english/ research/resprog-compintro.htm**
- Vascular Health and Dementia Operating Grants (Heart and Stroke Foundation, Alzheimer Society of Canada, CIHR Institute of Aging, CIHR Institute of Neurosciences, Mental Health and Addiction, CIHR/Rx&D Research Program, supported by Pfizer Canada) **http://www.hsf.ca/research/guidelines/vhdJfa.html http://www.alzheimer.ca/english/research/resprog-rfa-vascular.htm**
- Caregiving and Alzheimer Disease Research Grants Program (Alzheimer Society of Canada, Canadian Nurses Foundation, CIHR Institute of Aging and CIHR Institute of Gender and Health) **http://www.alzheimer.ca/english/research/resprog-rfa-caregiving.htm**
- Biological Mechanisms and Treatment of Alzheimer Disease Grants Program (Alzheimer Society of Canada, Astra Zeneca Canada and Astra Zeneca US, and CIHR) **http://www.alzheimer.ca/english/research/resprog-rfa-treatmenth.htm**

For more information contact:

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"About the time we can make ends meet, somebody moves the ends."

- Herbert Hoover